Group Teen Triple P: Promotion of parent self-regulation and effects on their adolescent children

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CONTENTS

ABSTRACT

The self-regulation approach to educating parents focusses on promoting parenting confidence, independence, and the ability to solve future problems. As parents learn the skills to modify their own behaviour, in turn, they aim to foster self-regulation in their children/adolescents.

A need had been identified by Christchurch school principals for the Ministry of Education to respond to the post-earthquake stress in local families. The aim of this study was to investigate if a parenting programme was effective in promoting parental self-management skills and adolescent behaviour change in Christchurch families affected by earthquakes between 2010 and 2012.

A single case research design was used to follow five families with adolescents (12-16 years old) as they participated in a Group Teen Triple P – Positive Parenting Programme. Measures of self-management skill acquisition were taken during three family discussions (pre-intervention, mid-intervention, and post-intervention) and during the three telephone consultations (Sessions 5-7). Adolescent target behaviour tallies were also analysed for change.

The main findings showed that parental self-management skill acquisition increased over-time accompanied by positive change in adolescent behaviour. Additionally, the results suggested that higher rates and levels of self-management skill acquisition in the parents were associated with greater improvements in adolescent behaviour. This study demonstrated that Group Teen Triple P – Positive Parenting Programme was effective in promoting self-management competencies in parents and behaviour change in adolescents.

CHAPTER 1

INTRODUCTION

1.1 Conceptualisation and Definition of Self-Regulation

Self-regulation strategies can be taught to help a parent modify their own behaviour and the behaviour of their child/adolescent (Sanders & Ralph, 2002). Promoting self-regulation in parents has become an important issue in parenting intervention research as it is associated with a number of positive life outcomes for children and adolescents. The capacity to self-regulate has been linked with better adjustment, higher self-esteem, academic success, higher income later in life, physical and mental well-being, happiness, better interpersonal skills, and better relationship quality (Moffitt, Arseneault, Belsky, et al. 2011; Tangney, Baumeister & Boone 2004). Deficits in self-regulation have been linked with poorer life outcomes including: problems with aggression, anxiety, and depression; delinquency and criminal behaviour; eating disorders; accidents; interpersonal and social problems; and drug and alcohol abuse (Moffitt et al. 2011; Tangney et al. 2004; Tsukayama, Toomey, Faith & Duckworth 2010; Tremblay, Boulerice, Arseneault & Niscale 1995). According to Moffitt et al. (2011), poorer self-regulation in early childhood predicts behavioural, health, social, and economic problems in adulthood. What is more, deficits in child self-regulation have been found to mediate the link between parental low self-regulation and adolescent delinquency (Higgens, 2009; Hay 2001).

Self-regulatory processes are rooted in a social context and involve a dynamic interaction between the individual and external factors present in each setting. Karoly (1993) defined self-regulation as, “those processes, internal and or transactional, that

enable an individual to guide his/her goal directed activities over time and across circumstances (contexts). Regulation implies modulation of thought, affect, behaviour, or attention via deliberate or automated use of specific mechanisms and supportive meta-skills. The processes of self-regulation are initiated when routine activity is impeded or when goal directedness is otherwise made salient (e.g., the appearance of a challenge, the failure of habitual patterns)", (p. 25). Sanders (2008) therefore, suggested that promoting self-regulation is "a process whereby individuals acquire the skills they need to change their own behaviour and become independent problem-solvers and controllers of their own destiny". Enhanced self-regulation empowers people to develop a sense of personal control over their own life (Sanders & Mazzucchelli, 2013). Bandura (1991) proposed that self-regulation regulates the effects of environmental influences and provides the foundation for decisive action. This suggests that an individual can change their thought, emotional responses and behaviour by giving attention to a challenge and by using certain skills and mechanisms to bring about the desired outcome.

1.2 Social Cognitive Theory

The concept of self-regulation stemmed from Albert Bandura's social cognitive Theory (Bandura, 1986, 1991). Bandura's theory was based around the idea that people possess the capability to be self-reflective and self-reactive which, in turn, gives them some control over their own thoughts, feelings, motivations, and actions. He suggested that people become self-directed when they use their personal standards to guide, motivate and control their actions. Bandura (1991) proposed that there were a number of sub-functions within the mechanism of self-regulation:

1 *Self-monitoring* refers to the practice of paying attention to one's performance in different contexts. The purpose of self-monitoring is to provide information that is needed for an individual to set realistic goals and to evaluate their progress. It also contributes to self-motivation and self-directed change.

2 *Judgement of actions* plays a major role in self-directedness by using personal standards to judge and guide one's behaviour. Social referencing, the value of the activity, and the individual's perceptions of the determinants of their success (internal ability vs. external aid) also exert influence on the judgements.

3 *Self-reactive influences* provide the mechanism that causes individuals to follow courses of action that lead to desired attainments and to avoid actions that lead to dissatisfaction of performance through self-censure.

Bandura (1986, 1989) also proposed that the mechanism of self-efficacy played a key role in the implementation of personal agency. Self-efficacy refers to an individual's beliefs about their capability to perform, or have control over, their own functioning and over environmental events. Personal agency is concerned with the individual's ability to own the change process by attributing the change to their own efforts rather than by chance or external influences.

1.3 Self-regulation Theory

This study will focus on the theories developed by Sanders and associates (Sanders & Mazzucchelli, 2013; Sanders & Ralph, 2002; Sanders, Markie-Dadds, & Turner, 2001) that seek to explain the key elements, functions and processes involved in fostering self-regulation in adults and children through parenting interventions. Sanders (2008) proposed that one of the key goals of parenting programmes is to strengthen parents' self-regulation.

Sanders and Mazzucchelli (2013) argued that parental self-regulation is essential to establish and uphold the positive and caring parenting practices that promote good outcomes for children. Sanders and Mazzucchelli (2013) described a number of benefits in building competence in self-regulation through parenting interventions. Firstly, parenting interventions can be more widely available and can be seen as normal. Secondly, large sections of the population can be reached. Thirdly, parenting interventions are financially viable, which in turn can lessen government expenditure. Fourthly, interventions can target specific developmental stages and, fifthly, the beneficial effects of the intervention may generalise to other areas of life.

The self-regulation approach to educating parents focusses on promoting parenting confidence, independence, and the ability to solve future problems. As parents learn the skills to modify their own behaviour, in turn, they aim to foster self-regulation skills in their children/adolescents. According to Sanders, Markie-Dadds and Turner (2001, p.17), these skills include: a) selecting personal parenting goals and developmentally appropriate goals for their child/adolescent; b) choosing an appropriate strategy for intervention; c) implementing the strategy; d) self-monitoring of the implementation of the strategy; e) identifying the strengths and weakness of their performance; f) and setting future goals for behaviour change.

1.4 The Self-Regulation Framework

Sanders and Mazzucchelli (2013) developed a unifying self-regulation framework to help explain the process of increasing parental capacity to change and/or modify their own behaviour by identifying the following essential elements presented in Figure 1.

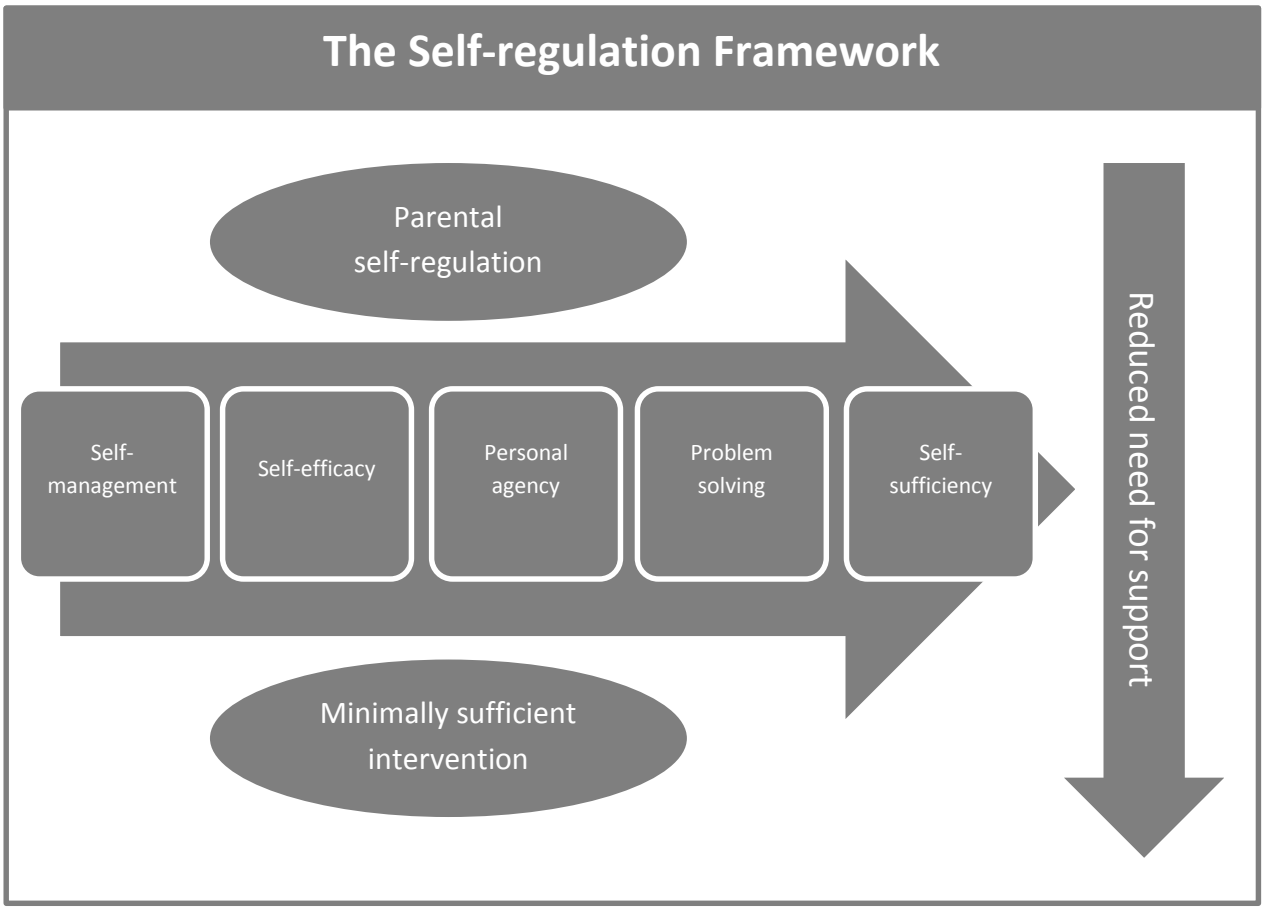

Figure 1: The Self-regulation Framework (from Sanders, Markie-Dadds & Turner 2014, p. 16)

1. *Self-management.* There are a number of self-management skills that parents need to acquire to develop self-sufficiency. Some of these skills include: self-monitoring of wanted and unwanted behaviours; self-determination of goals; self-selection of change strategies; self-evaluation of performance; and self-reward.

2. *Self-efficacy.* This refers to the parent's confidence in their ability to refrain from maladaptive strategies and utilise adaptive strategies to bring about behaviour change. It also refers to the belief that one can bring about positive change in the future.

3. *Personal agency.* During the course of the intervention the parents are prompted and encouraged to recognise that the positive changes are due to their own efforts. Personal agency is strengthened by substituting attributions for changes in behaviour, emotions and cognitions (self and child) from other influences (e.g. chance, maturation, genetic make-up) to their own efforts and competency. Sanders and Ralph (2002) hypothesised that self-sufficient parents are more likely to seek appropriate support when needed, advocate for their child/adolescent, protect them from harm, and continue to be involved in their education.

4. *Problem solving* is an important aspect of a self-regulatory parenting intervention. Becoming an independent problem solver means that the parents learn to trust their own judgements and can transfer the new parenting skills, learned during the intervention, across behaviours, settings, siblings, and over-time. Over time the parents demonstrate a reduced need for support. Sanders and Ralph (2002) posit that a successful parenting intervention builds a parent's capacity to solve a wide range of family problems beyond the present issues.

5. *Self-sufficiency.* An effective parenting programme helps the parents move from reliance on others (e.g. professional therapists) in fulfilling their fundamental

parenting responsibilities to becoming an independent and confident parent. Establishing self-sufficiency requires the parent to strengthen their knowledge, skills, resourcefulness and resilience.

1.5 The self-regulating parent

Sanders and Mazzucchelli (2013) proposed an operationalised definition of parental self-regulation by considering the characteristics of the parent with strong capabilities to self-regulate. The following paragraph summarises their operational definition. The self-regulating parent: (a) is clear about what types of behaviours, values and skills she wants to develop in herself, her child, and her home; (b) has realistic expectations for herself and those who care for her child; (c) understands what can be expected of her child during the different stages of their development; (d) would be automatically monitoring her performance against her standards; (e) would bring her usual behaviour under control when she detects a discrepancy between a behaviour and her personal standards; (f) would deliberately attend to the behaviours and gain information to help her hypothesise why the discrepancy has occurred; (g) would have a wide range of knowledge and skills to draw from when developing a plan of action; (h) would carry out her plan, evaluate the outcome, and revise the plan if needed until the desired outcome is achieved; (i) her new behaviour would then become automatic; (j) she would have positive expectations for using her plan to achieve good outcomes in the future; (k) she would self-reflect and be able to identify her strengths, weaknesses, successes, and failures so that she can grow in her competence and confidence as a parent; (l) she would be able to manage the emotional states that may interfere with her goals; (m) and she would mostly enjoy the parenting experience.

1.6 Promoting self-regulation in children

The main outcome of strengthening parental self-regulation is that parents develop the capacity to foster self-regulation in their children and adolescents. Sanders and Mazzucchelli (2013) stated that parents can promote self-regulation in their children and adolescents by consistently modelling and applying positive self-regulation strategies and by teaching the skills outlined above in developmentally appropriate ways. These researchers posit that building self-regulation skills in children/adolescents provides them with powerful life tools that, in turn, increases their chances of achieving positive life outcomes. Sanders and Mazzucchelli (2013) proposed that specific parenting practices can be taught in effective parenting programmes to foster self-regulation skills in children and adolescents. These are: a) *Incidental teaching,* which can be used to prompt a child to solve a problem themselves by providing a clue rather that an answer; b) use of *Ask-say-do* strategy that can promote independence in tasks by using the least intrusive prompt; c) *Positive attending* to the child*'s* attempts to control their own emotions so as to develop emotional regulation; d) *Asking a child to reflect/review their own performance,* which develops the skill of self-monitoring; e) *Asking a child to describe their successes and accomplishments*, which promotes self-evaluation; and f) *Asking a child to talk about their own expectations,* which helps create positive expectancy for change.

1.7 Promoting self-regulation in post-earthquake Christchurch families

This research was carried out in Christchurch, New Zealand, which was at the centre of the major earthquakes that occurred during 2010 - 2012. The families who lived through the extended impact phase of the earthquakes suffered from high levels of stress caused by threats to well-being, bodily injury and to life itself. Secondary stressors also greatly

affected many individuals and families. These included: damage to and loss of homes; school closures; schools sharing campuses; business closures; unemployment; loss of electricity; loss of clean water supply; loss of sewage services; petrol shortages; evacuation; loss of possessions; disruption to health care services; hospitalisation; separation from loved ones; loss of community; shortage of basic necessities; disruption of transport; damage to roads; and television channels that displayed graphic images of the disaster repeatedly over an extended period of time. According to Shaw, Espinel and Shultz (2012, p.14), as the number of traumatic events (e.g., repeated earthquakes) is experienced, an individual is more at risk of developing emotional problems, behavioural problems and negative coping strategies. As a response to the needs of post-disaster Christchurch families, the Ministry of Education considered an intervention that promotes parental self-regulation was appropriate to help parents restore their family functioning and child/adolescent well-being.

1.8 Summary

The self-regulation approach to parent training encourages each parent to take responsibility for deciding on what behaviours need to change in themselves and their child/adolescent and what strategies, from the range offered in the parenting programme, they wish to apply to bring about that change. The self-management tools provide the steps required to implement the chosen strategies, thereby increasing the likelihood of achieving the desired change in parent and child\adolescent behaviour. It is therefore, very important that a parenting programme, aimed at enhancing child/adolescent self-regulation, firstly develops the parents' own capacity to self-regulate.

In the next chapter, the research on parenting programmes is reviewed to establish the evidence that such interventions do promote parental self-regulation.

CHAPTER 2

LITERATURE REVIEW

2.1 Purpose of review

A systematic literature search was done to find evidence that parenting programmes actually do foster self-regulation in parents and promote changes in behaviour in children and adolescents. Moreover, the purpose of the literature search was to identify parenting programmes that show promise for promoting self-regulation, improve family functioning, and fostering positive changes in child/adolescent behaviour in post-earthquake Christchurch families. The two main considerations for the inclusion criteria were: a) that the parenting programmes have a strong evidence-base; and b) a parental self-regulation measure was used to examine outcomes and showed positive effects.

2.2 Evidence-based parenting programmes

Firstly, evidence based parenting programmes were identified by using the classifications published by *The California Evidence-Based Clearinghouse for Child Welfare Information and Resources for Child Welfare Professionals (CEBC)* website (http://www.cebc4cw.org/topic/parent-training/). The CEBC was created in association with the California Department of Social Services to "identify and disseminate information regarding evidence-based practices relevant to child welfare." The criteria for determining empirically validated treatments included replication, treatment manuals, and specified client characteristics. The classification system developed by the CEBC presented each peer-reviewed research on the following rating scale: 1 – well-supported by research evidence; 2

– supported by research evidence; 3 – promising research evidence; 4 – evidence fails to demonstrate effect; 5 - concerning practice; to NR – not able to be rated. The CEBC advisors included parenting programmes as a topic area as it was considered critical for child welfare agencies to know what works for families. CEBC defined parent training programmes as "services to help parents improve their parenting of and communication with their children, with the goal of reducing the risk of child abuse and neglect and/or reducing disruptive behaviours." The CEBC included a variety of formats (e.g., individual, group, parent-child dyad, video, online courses and books) that had an overall focus of the programme being on parent training (i.e., skill building). In order to be rated by the CEBC, and as specified by the CEBC Scientific Rating Scale, the parenting programmes were required to show research evidence in the examined outcomes of: a) parenting behaviour, e.g., decreases in use of harsh discipline; b) reductions in child abuse and neglect, e.g., reduction in self-reports and re-reports of maltreatment; and/or c) improvements in child behaviours, e.g., reductions disruptive behaviours. For the purpose of this study, Classification One (well-supported by research evidence) parenting programmes were identified. Table 1 presents the parenting programmes reviewed by the CEBC that achieved a rating of 1 according to the Scientific Rating Scale.

Table 1.

Parenting programmes with a scientific rating of 1, well-supported by research evidence, as classified by the CEBC using the Scientific Rating Scale

Programme	Topics	Target Population
The Incredible Years (IY) (Webster-Stratton, 1998a, 1998b; Webster-Stratton & Herbert, 1994)	Child/adolescent disruptive behaviour treatment, parent training, programmes, prevention of child abuse/neglect	Parents Teachers Children 4-8 years
Oregon Model, Parent Management Training (PMTO) (Forgatch & Patterson, 2005)	Child/adolescent disruptive behaviour treatment, parent training	Parents of children 2-18 years with disruptive behaviours
Parent-Child Interaction Therapy (PCIT). (Eyberg & Members of the Child Study Laboratory, 1999)	Child/adolescent disruptive behaviour treatment, parent training	Children 2-7 years with behaviour and parent/ child relationship problems, parents, foster parents, other
Triple P – Positive Parenting Program (Level 4 Triple P) (Sanders, Markie-Dadds & Turner, 2001)	Child/adolescent disruptive treatment, parent training	Parents/caregivers of children/adolescents with moderate to severe behavioural/emotional difficulties
Attachment and Biobehavioral Catch-up (ABC) (Dozier, Lindheim, & Ackerman, 2005)	Increase caregiver nurturance Decrease caregiver frightening Increase child attachment security Increase child behavioural and biological regulation	Parents/caregivers of children ages 0-2 who have experienced early adversity

2.3 Parental self-regulation measures

Secondly, the self-regulation measures recommended by Sanders and Mazzucchelli (2013) for assessing competence in adults/parents were located. A search was done, using academic data bases at the University of Canterbury (PsycINFO, PsycARTICLES, ScienceDirect, PubMed and Google Scholar), by following the citations of the primary references for each

self-regulation measure to find if any of the above well-supported evidence-base parenting programmes had used them as outcome measures. Table 2 presents the measures of adult/parent self-regulation that were included in the search.

Table 2.

Measures of adult/parent self-regulation

Measure	Description	Reliability/Validity
Self-Control Scale (SCS). (Tangeny et al., 2004)	36-item instrument designed to assess controlling thoughts, feelings, impulses, performances, and breaking bad habits. 13-item short form has also been developed.	High internal consistency for long and short forms ($\propto =$ .89 and .83). Test-retest reliability (*r* = .89 and .87).
Self-Control and Self-Management Scale (SCMS). (Rohrbeck et al., 1991)	16-item instrument designed to assess three traits – self-monitoring, self-evaluation and self-reinforcing .	The three sub-scales and total scales have shown satisfactory internal consistency ($\propto =$,74, .75, .78 and .81). Test-retest correlation of .75
Parenting Sense of Competence Scale (PSOC). (Gibaud-Wallston and Wandersman (1978, cited in Johnston and Mash, 1989)	17-item scale designed to assess parenting self-esteem. Two sub-scales (satisfaction and efficacy) and total.	Satisfactory internal consistency ($\propto$ = .75, .76, and .79) for satisfaction, efficacy and total. Test-retest correlations ranged from .46-.82. Significant inverse relationships found PSOC and perception of child behaviour
Parental Locus of Control Scale (PLOC). (Campis et. al. 1986)	47-item scale designed to assess parental locus of control. Five sub-scales: parental responsibility, parental efficacy, child control, fate/chance and parental control	Alpha coefficients: .79 (parental responsibility), .66 (child control), .70 (fate/chance), .71 (parental control) and .44 (parental efficacy). Correlations between five subscales and validation measures suggest parents with external locus of control had low self-efficacy, a sense that child was in control and a belief in fate and chance.
Parenting Self-Agency Measure (PSAM). (Dumka et al. 1996)	5-item measure designed to assess parenting self-agency (confidence in ability to act successfully in parental role	Alpha coefficients for Anglo and Mexican immigrant groups were .70 and .68 respectively. Anglo group: PSAM positively correlated to active coping and parenting acceptance, negatively correlated to parenting inconsistent discipline. Mexican group: PSAM positively correlated to positive reinterpretation coping and parenting acceptance.

Self-Efficacy in Parenting Tasks Index (SEPTI). (Coleman and Karraker, 2000).	36-item scale designed to assess domain specific self-efficacy in parents of primary school children. Five subscales: facilitating child's achievement in school, supporting child's need for recreation and socialising with peers, provision of structure and discipline, provision emotional nurturance and maintenance of child's health.	Satisfactory internal consistency for achievement (.74), recreation (.82), discipline (.86), nurturance (.77), health (.73) and total scale (.91). Test-retest correlations ranged from .46 to .82. SEPTI total and parent-outcome expectations scale converged with other self-efficacy measures, child temperament measures and Satisfaction with parenting measures.
Parenting Tasks Checklist ((PTC) (Sanders and Woolley, 2005)	28-item checklist designed to assess parents' task specific self-efficacy. Two sub-scales: behavioural self-efficacy and setting self-efficacy.	Good internal consistency: behavioural self-efficacy scale (.97) and setting self-efficacy scale (.91). PTC discriminated between clinic and non-clinic mothers. Self-efficacy score were significant predictors of maternal discipline style (behavioural self-efficacy best predictor).
The Early Intervention Parenting Self-Efficacy Scale (EIPSES). (Guimond et al., 2008)	16-item measure designed to assess parenting efficacy in context of early intervention. Two subscales: parent-outcome expectations and parent competence.	Acceptable consistency for parent-outcome scale (.64), competency scale (.75), and total scale (.80). Parent-outcome expectations scale and total scale converged with measures of child receptive communication, internalising, externalising and dysregulation.
Me as a Parent (MaaP). (Hamilton et. al., 2013)	16-item scale designed to assess Parents' global beliefs of self-efficacy, personal agency, self-management, and self-sufficiency	Good internal consistency for: self-efficacy (.75), personal agency (.63), self-management (.72), self-sufficiency (.65) and total scales (.85). Test-retest correlation for total score was .71. M MaaP total scale and self-efficacy scale

2.4 Results of literature search

The following studies were found that showed evidence of the researched parenting programmes fostering self-regulation in parents and improvement in child/adolescent behaviour. Table 3 presents the results of the literature search. Cohen's *d* had been used to report the effect size (standardised mean differences) between pre-test mean and post-test means.

Table 3.

Results of literature search

Parenting Programme	Participants	Self-regulation measures	Findings
The Incredible Years			
Axberg and Broberg (2012)	Parents of 62 children (4-8yrs) diagnosed with ODD.	PLOC	Statistically significant positive effects for Swedish children's disruptive behaviour in treatment group compared to waitlist group. Mothers in both groups reported more parental control (PLOC): effect size high in treatment group (d=1.27) and medium in waitlist group (d =o.66).
Gardner, Burton and Klimes (2006)	Parents of 76 children (2-9 yrs) referred for conduct problems	PSOC	Post-treatment improvements in parent reported child problem behaviour (*d* = .48, *p* = .05); direct observation (*d* = .78, p = .04) ,child independent play (*d =.77, p* = .003), observed negative and positive parenting (*d* = .74, *p* = .003; *d* = .38, *p* = .04), parent reported confidence and skill (PSOC) (*d= .40, p* = .03; *d* = .65, *p* = .01).
Parent-child interaction Therapy			
Nixon, Sweeny, Erickson and Touyz (2003)	Families of 54 behaviourally disturbed preschool-aged children (3-5yrs)	PSOC PLOC	Significant differences in parent- reported externalising behaviours in children and parental stress and discipline practices. Two treatment groups reported more satisfaction (PSOC) and more control (PLOC) compared to waitlist group. Three-group ANCOVA *F values:* PSOC 5.64** and PLOC 10.09***

McCabe, Yeh, Lau and Argote (2012)	Mexican American families of 58 children (3-7yrs) with clinically significant behaviour problems	PLOC	Significant pre-post improvement in conduct problems, especially for culturally modified version treatment group. PLOC results: standard PCIT group (*d* = .61); treatment as usual group (*d* = .41); culturally modified PCIT (*d* = 1.34).
Triple P-Positive Parenting Programme			
Kirby and Sanders (2014)	Fifty-four grandparents and 48 parents randomly assigned to intervention or grandparent care-as-usual conditions.	PTC	Significant decrease in scores for child behaviour problems in treatment group (intensity $F(1,27)=39.55, p<.001$; problems $F(1,27)= 16.59$, $p <.001$). PTC results showed a significant improvement for behaviour self-efficacy in intervention condition ($F(1,27) =9.53, p=.005$).
Au, Lau, Wong, Lam, Leug, Lau & Lee (2014)	Seventeen parents of children (aged 5-10 years) diagnosed with ADHD randomly assigned to intervention group or control group.	PSOC	Significant reduction in intensity of child behaviour problems ($F=3.16$). Significant increase in parenting efficacy ($F=1.47$) for Intervention group.

The following section describes the three parenting programmes identified in the literature search that are well-supported by scientific evidence and have used parental self-regulation measures to assess change.

2.5 The Incredible Years Programme

The Incredible Years Series (http://www.cebc4cw.org/program/the-incredible-years/detailed) is a set of three programmes that interlock, are developmentally based, and very comprehensive. They are designed to be delivered to children, parents and teachers. The Incredible Years (IC) programmes are based in developmental theory and focus on the

role of “multiple interacting risk and protective factors in the development of conduct problems”. The main goal is to reduce delinquent behaviours, reduce school drop-out, and to promote academic success. The series of programmes work together to promote academic, social and emotional competence and to treat and reduce emotional and behavioural problems in children. The content of the programmes is structured around video vignettes to model parenting practices to encourage group discussion and problem solving so as to help participants achieve their goals.

The Incredible Years programmes have been found to have positive effects on foster carers’ depression and foster child problem behaviours (Bywater, Hutchings, Linck. Whitaker, Daley, Yeo, and Edwards, 2011); conduct problems in boys and younger children from a socially disadvantaged neighbourhood (Gardner, Hutchings, Bywater, & Whitaker, 2010); children diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (Drugli, Larsson, Fossum & Morch, 2010); child behaviour, parent behaviour, parental stress and depression in parents of children aged 36-59 months at risk of developing CD (Bywater, Hutchings, Daley, Whitaker, Yeo, Jones, & Edwards, 2009); and increases in appropriate discipline and decreases in harsh discipline in Korean American mothers of young children (Kim, Cain, and Webster-Stratton, 2008). Table 4 presents the three programmes offered by Incredible Years.

Table 4.

Incredible Years Programmes

Programme	Target Population	Target Skills
Parenting Programme	Separate programmes for: Babies (0-1) Toddlers (1-3) Pre-schoolers (3-5) School age children (6-12)	Strengthen parent/child attachment and interactions; reduce harsh discipline; foster parent's competence to promote child development (social, emotional and academic success) and school readiness. Encourage parent/teacher alliance.
Child Programme	Pre-school First grade Second grade	Developing child social and emotional skills; understanding and communicating feelings; managing anger; friendship and conversation skills; and appropriate behaviour in classroom.
Teacher Programme	Early childhood teachers and Elementary (Primary) teachers of children 3-8	Classroom management strategies; promoting prosocial behaviour, emotional self-regulation and school readiness in students; reducing student aggression and non-cooperation; and

Axberg and Broberg (2012) evaluated the transferability of The Incredible Years parent training programme for clinical work with a Swedish population. Using a randomized controlled design, parents of 62 children, aged four to eight years old, diagnosed with Oppositional Defiant Disorder were assigned to either treatment group (n=38) or waitlist group (n=24). They reported that the results showed positive effects on child disruptive behaviour problems. A statistically significant difference was found in between intervention group and waitlist group, with the greatest reduction in problem behaviours in favour of the intervention group. The measure used in this study to detect changes parental self-regulation was the Parental Locus of Control (PLOC) (Campis et al. 1986). Mothers in both groups reported more parental control, however the PLOC results for treatment group

produced a large effect size (*d*=1.27) and the waitlist group results showed a medium effect size (*d*=0.66). Axberg and Broberg (2012) also reported that the participating mothers were receptive towards the Incredible Years programme and found the parenting methods learned useful and appropriate. This study provides additional support for the use of the Parental Locus of Control Scale as an assessment tool for parenting programmes.

Gardner, Burton and Klimes (2006) investigated the effectiveness of the Incredible Years programme, delivered in a community-based organisation, for reducing conduct problems in children. Parents of 76 children (aged two to nine years), who had been referred for conduct problems, were randomly assigned to either the treatment group or the waitlist group. The result showed post-treatment improvements in parent-reported child problem behaviour and in direct observation of independent play, negative parenting and positive parenting. The measure used to investigate changes in parental self-regulation was the Parent Sense of Competence scale (PSOC. Johnston and Mash, 1989). The results showed medium effect size improvements in parenting satisfaction and efficacy. Gardner et al. (2006) concluded that the Incredible Years programme can be effective in the community voluntary-sector if it is delivered by well-trained staff. They also suggested that changes in parenting skill appeared to be the key mechanism for changes in child behaviour. This study also provides evidence for the usefulness of the PSOC for assessing the parental self-efficacy component of the self-regulatory model, however, it also highlights the need to investigate the parenting skills associated with the development of self-regulation (e.g., parental self-management skills).

2.6 Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) (http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed) is a behavioural intervention for parents and caregivers and their children (aged 2-7 years). The main aims of the programme are to decrease externalizing child behaviour problems, increase child cooperation and social skills, and improve the parent-child attachment relationship. Parents are taught traditional play-therapy skills to reinforced positive behaviours and traditional behaviour management skills to decrease child behaviour problems. The parents practice the skills under the guidance of the therapist, who provides with immediate feedback to help them master each competency. The intervention length depends on how long it takes for each family to demonstrate mastery of skills, however the hour-long weekly sessions usually average about 14 weeks. Previous research has found that PCIT has been effective at decreasing conduct, oppositional and behavioural problems and increasing compliance and desired behaviours in children. It has also been found to significantly improve parenting skill, parent well-being parenting confidence and child behaviour in families of 3-6 year old children diagnosed with conduct disorder (Shuhman, Foote, Eyberg, Boggs & Algina, 1998); families of young children who met the criteria for ODD (Nixon, Sweeny, Erikson & Touyz, 2003); mothers of children who had been diagnosed with mental retardation(MR) and ODD (Bagner & Eyberg, 2007); Chinese families with children aged 3-7 years old from social service centres (Leung, Tsang, Sin & Choi, 2015); and foster families (Mersky, Topitzes, Grant-Savela, Brondino & McNeill, 2014). Additionally, PCIT has been found to reduce negative parent behaviour and an intervention group had significantly fewer re-reports of abuse (Chaffin, Silovsky, Fundervurk, Valle, Brestan, Balachova & Boner, 2004).

PCIT is a dyadic behavioural intervention that is delivered in two phases. The first phase is where the parent learns to let the child lead the play, and the second phase is where the parent leads the play. The essential components of each phase are presented in Table 5.

Table 5.

Essential components of phase one and two of PCIT

Interaction Phases	Components
Child-Directed Interaction	Parent-child play together, parent learns to follow child's lead
(Phase One)	Parent learns how to increase positive communication and decrease negative interactions
	Parent learns to give attention to positive behaviour and ignore negative behaviour
	Parent taught to use descriptive praise, reflect child language, and avoid commands, questions and criticism
	Parent coached through one-way mirror utilizing a 'bug in the ear' device and given direct feedback
	Parent skills observed, recorded and assessed in first 5 minutes of each session
	Child behaviours tracked and recorded on a graph
	Homework tasks given to parent

Parent-Directed Interactions	Parent learns skills to lead the child in play
(Phase Two)	Parent taught how to direct child behaviour and promote compliance
	Parent observed through one-way mirror utilizing a 'bug in the ear' device and given direct feed back
	Parent skills observed, recorded and assessed in first 5 minutes of each session
	Parent learns to use effective commands and instructions
	Parent learns to use descriptive praise following compliance and learns to use time-out for non-compliance
	Behaviours are tracked and recorded on a graph. Immediate feedback given
	Homework tasks given to parent as mastery of skill increases
	Intervention ends when parent mastery criteria is met

Nixon, Sweeny, Erickson and Touyz (2003) investigated the effectiveness of standard PCIT and abbreviated PCIT in reducing conduct-problem behaviours in children, parental behaviours, parental beliefs and discipline practices. Fifty-four families of behaviourally disturbed preschool-aged children (3-5 years) were assigned to one of three conditions, standard PCIT, abbreviated PCIT, and wait-list group. The findings showed significant differences in parent-reported externalising behaviours in children, parental discipline practices and parental stress from both treatment groups when compared to the wait-list group. Additionally, participants from both treatment groups reported more satisfaction (PSOC) and more control (PLOC). The authors concluded that the standard PCIT had superior effects immediately after the intervention however, by six month follow-up measures were comparable from both treatment groups. This study also provided support for measuring changes in parental sense of competence and parental locus of control when evaluating the effectiveness of a parenting programme.

McCabe, Yeh, Lau and Argote (2012) examined treatment effects ,over 6-24 months post-intervention, for externalizing behaviours in 58 young children (3-7 years) from Mexican American families with clinically significant behaviour problems. The families were randomly assigned to one of three conditions, Standard PCIT, Culturally Modified PCIT (adapted for Mexican Americans), and treatment as usual groups. All treatment groups produced significant improvements in conduct problems, however the culturally-modified PCIT treatment results were superior to treatment as usual results in 6 out of 10 parent-report measures 6 to 24 months post-intervention. Additionally, the culturally-modified PCIT group significantly outperformed the standard PCIT group for child internalizing symptoms. Parental locus of control (PLOC) results also showed the superior effects for the Culturally Modified PCIT treatment group (*d* = 1.34), and medium effects were found in the standard PCIT group (*d* = .61) and the treatment as usual group (*d* = .41). The authors concluded that developing cultural modifications to parenting programmes is a potentially promising direction for future research.

2.7 Triple P-Positive Parenting Programme

Triple P-Positive Parenting Programme (Triple P) (http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triplep/detailed) is a parenting intervention, offered in a multi-level system, for parents of children who either have problem behaviours or who are at risk of developing behaviour problems. This programme aims to prevent emotional, behavioural and developmental problems by promoting positive and caring parent/child relationships and by helping parents acquire effective management strategies to deal with a number of childhood problems and issues (Sanders, Markie-Dadds, and Turner, 2001).

Triple P is an evidence based programme developed through clinical research (Sanders, 1996, 1999; Sanders, Markie-Dadds, Tully and Bor, 2000). The self-regulatory training methods utilised in Triple P have been shown to be effective in decreasing disruptive behaviour in a number of populations, including children in step-families (Nicholson and Sanders, 1999), children at risk of developing conduct problems (Markie-Dadds and Sanders, 2006); children of depressed parents (Sanders and McFarland, 2000); children from martially discordant families (Dadds, Schwartz and Sanders, 1987; Ireland, Sanders and Markie-Dadds, 2003); children with persistent feeding problems (Turner, Sanders and Wall, 1994); children with behavioural problems in rural and remote areas (Connell, Sanders and Markie-Dadds, 1997); and children with mild and moderate intellectually disabilities (Harrold, Lutzker, Campbell and Touchette, 1992).

Triple P offers five levels of intervention on a continuum of increasing intensity. The five levels of Triple P are presented in Table 6.

Table 6.

Triple P Parenting Programmes

Level of Intervention	Target Population	Target Behaviours
1.Universal Triple P Parenting information - media campaign development	All parents interested in knowledge about parenting and promoting child development.	Common behavioural and developmental problems. General parenting issues.
2.Selected Triple P Information and advice for specific parenting issues.	Parents with specific worries about their child's development or behaviour.	Common behavioural and developmental transitions
3.Primary Care Triple P Narrow focus on specific parenting skills training.	Parents who require consultations/active skills training for specific concerns.	Specific child behaviour problems, e.g., tantrums
4.Standard Triple P *Group Triple P* *Self-directed Triple P* *Teen Triple P* Broad focus parenting skills training	Parents wanting intensive training in parenting skills. Parents of children with more severe problem behaviours.	Multiple problem behaviours. Aggressive behaviours. Oppositional defiant disorder. Conduct disorder. Learning difficulties.
Enhanced Triple P Behavioural family intervention	Parents of children with concurrent problem behaviours and family dysfunction.	Concurrent child problem behaviour and parent problems (e.g., depression)

Kirby and Sanders (2014) investigated the efficacy of a Triple P programme specifically designed for grandparents (Grandparent Triple P). Fifty-four grandparents and 48 parents were randomly assigned to either an intervention group or care-as-usual group. The Parenting Tasks Check List (PTC) was included, with the standard measures, to assess changes in parenting confidence for managing child behaviour and for managing in different settings. Compared to the grandparent care-as-usual group, the results showed significant short-term improvements for the intervention group on grandparent reported child behaviour problems; grandparent depression, anxiety and stress levels; and

parent/grandparent relationships. The PTC results showed a significant improvement for behaviour self-efficacy for the grandparents in the intervention condition. The authors also reported that the short-term effects were found to be predominantly maintained at follow-up (6 months). It was concluded that grandparent and parents could be included in parenting programmes to increase the exposure of positive parenting practices to children and thereby help create a better nurturing environments.

Au, Lau, Wong, Lam, Leung, Lau, and Lee (2014) evaluated the efficacy of Group Triple P – Positive Parenting Programme with Hong Kong Chinese parents who had children diagnosed with attention deficit/hyperactivity disorder (ADHD). Seventeen parents were randomly assigned to either intervention group or control group. The PSOC (Gibaud-Wallston and Wandersaman, 1978) was included as an assessment tool, along with the standard measures used by Triple P. The results showed that, compared to the control group, the Group Triple P group reported significant reduction in intensity for child behaviour problems. The PSOC results also showed a significant improvement in parenting efficacy. The overall gains were maintained at three month follow-up. What is more, the authors reported that the qualitative data suggested that the key elements that helped the parents and children make positive changes were: understanding and empathy, emotional control, and the parents being persistent in applying the positive parenting strategies.

2.8 Summary

In summary, evidence has been found that three parenting programmes, Incredible Years Programme, Parent-Child Interaction Therapy, and Level Four Triple P – Positive Parenting Programme, promote parental self-regulation along with positive changes in child behaviour. The measures used in these studies focussed on measuring parenting sense of

competence and parental locus of control. One study measured task specific self-efficacy (behaviour and setting). The studies found in this literature review strengthen Sanders' and Mazzucchelli's (2013) theory that parental self-efficacy is an important element in the process of increasing parental capacity to change and/or modify their own behaviour. However, more research is needed to examine the role of personal agency, self-management, and self-sufficiency in the development of parental self-regulation. In conclusion, the three parenting programmes, identified above, show promise for promoting self-regulation, improve family functioning, and fostering positive changes in child/adolescent behaviour in post-earthquake Christchurch families.

In the next chapter the rationale for the current project is explained. The aim of the study, the main focus of the investigation, the design, and the research questions are also presented.

CHAPTER 3

RATIONALE

3.1 Importance of the Present Study

Self-regulation can be understood as located within the individual, however in the family context, the development of self-regulation in children involves dynamic and reciprocal interactions between the family members. Sanders and Mazzucchelli (2013) state that promoting child self-regulation begins with enhancing parenting confidence and independence. As discussed earlier, the self-regulatory framework (Sanders and Mazzucchelli, 2013) helps to explain the process of learning the skills to modify one's behaviour by identifying a number of essential competencies. Previous research has investigated and measured different traits and dimensions of self-regulation, for example, self-control, self-esteem, personal agency, locus of control, outcome expectations, self-sufficiency, and self-evaluation (Hamilton, Matthews & Crawford, 2013; Mezo, 2009; Guimond, Wilcox, & Lamorey, 2008; Sanders and Woolley, 2005; Dumka, Sstoerzinger, Jackson, & Roosa, 1996; Campis, Lyman, & Prentice-Dunn, 1986). Additionally, prior research has investigated and measured changes in the dimension of parental self-efficacy in response to parenting interventions (e.g. Kirby & Sanders, 2014; Nixon, Sweeney, Erickson & Touzy, 2003; and Gardner, Burton & Klimes, 2006). However, Sanders and Mazzucchelli (2013) highlighted that there still remains a gap in how to best measure other self-regulation processes and suggested that further study is required to investigate the occurrence of competencies, such as the acquisition of self-management skills, that are used within the family context to bring about behaviour change. Self-management skills are an

essential feature of an effective parenting programme as they help parents to put in to practice the change strategies. In order to address this gap and to examine Sanders and colleagues theory of the self-regulatory processes, this study aims to track the occurrence of the self-management competencies used to bring about changes in parent and adolescent behaviour in response to the Group Teen Triple P programme.

3.2 Current project

This project arises from a request by the Ministry of Education (MoE) to University of Canterbury staff to assist in evaluating a parenting programme the Ministry was preparing to deliver to selected Christchurch schools. Originally, the MoE designed the programme to be delivered in schools by school counsellors, formerly trained by the Triple P organisation (www.triplep.net), in response to post-earthquake needs identified by school principals. However, this was not feasible as school counsellors were over-committed and it was decided that the GTPPP programme would be delivered at the Pukemanu-Dovedale Centre, run by the Child and Family Psychology Programme at the University of Canterbury. Group Teen Triple P – Positive Parenting Programme (GTPPP) is a parenting intervention delivered over eight weeks for parents of adolescents up to 16 years old where the parents are interested in improving their parenting skills. Additional homework tasks are completed between weekly sessions. It was delivered by the Director of the Pukemanu-Dovedale Centre, a trained Triple P facilitator and registered clinical psychologist. The researcher was a Child and Family Psychology Master's Thesis student studying at the University of Canterbury.

3.3 Group Teen Triple P

Group Teen Triple P (GTPPP) is a Level 4, eight session programme designed for parents of adolescents (12 – 16 years of age) who want intensive training in positive parent skills. GTPPP uses the self-regulation approach to parent training by encouraging the parents to take responsibility for deciding on what behaviours they need to change in themselves and their adolescents and what strategies (taught in the programme) they wish to use to achieve their goals. This programme is usually conducted in groups of 10-12 parents and employs a process of active skills training to help parents gain new knowledge and skills for parenting adolescents. This includes information and strategies about positive parenting, factors influencing adolescent behaviour, encouraging appropriate behaviour, developing positive relationships with adolescents, promoting adolescent development, managing misbehaviour, dealing with emotional behaviour, dealing with risky situations and risky behaviours, and establishing family routines. The GTPPP programme begins with four two-hour group sessions that provide parents with information, demonstrations of parenting skills (via video segments from *Every Parent's Guide to Teenager) (*Sanders & Ralph, 2002), group discussions, practice opportunities, and feedback to help them learn. The parents are also required to complete homework tasks between each session to help them acquire the new skills. Following the first four group session, the participants receive individual 15-30 minute telephone consultations once a week for three consecutive weeks. During the consultations, the facilitator coaches the participants as they put into practice the change strategies, thereby prompting the development of the self-management skills. These sessions are designed to provide the individual families with the help they need to put into practice the positive parenting skills they have learned in Sessions 1-4. The telephone

sessions are also tailored to the needs of the individual families and support the parents as they transfer/generalise the skills across different situations. The final session is with the group again to provide an opportunity to review and consolidate progress. The main benefits for parents of working in a group include the friendship, support and helpful feedback from other parents and the opportunity to normalise their experiences through peer interaction (Sanders and Ralph, 2002).

3.4 Aim of study

Although Group Teen Triple P uses a self-regulatory approach to training parents, there is no scale to measure change in parental self-management skills proficiency in the *Facilitators Manual* (Sanders & Ralph, 2002). There is a need to reliably measure the acquisition of the specific set of competencies (i.e., the eight parental self-management skills) fostered in Group Teen Triple P that help parents produce desired change in child/adolescent behaviour. Additionally, more attention needs to be given to investigate if the changes in parental self-management capacity mediate changes in child/adolescent behaviour. This research aims to follow up to five families already participating in the programme from baseline, through intervention, to post-intervention in order to evaluate Group Teen Triple P in helping parents acquire and implement the parenting skills associated with promoting self-regulation.

3.5 Parental Self-Management

As discussed in Chapter One, strengthening parental self-regulation by building competence in parental self-management skills will help promote good outcomes for child/adolescent behaviour. The parental self-management skills are a higher order set of

skills required to implement the change strategies to produce desired outcomes. Eight self-management competencies have been identified by Sanders and Ralph (2002) and Sanders and Mazzucchelli (2013) as necessary tools for a parent to use to become a more self-sufficient problem solver.

The specific self-management competencies that will be tracked include:

1. *Goal setting* - The parent determines what changes in their child's behaviour they intend to change (e.g., completing family chores; tidying bedroom; speaking respectfully).
2. *Monitoring of behaviour* - The parent monitors how often the specific parent and adolescent target behaviours occur over the course of the baseline and intervention (e.g., uses behaviour diary or frequency tallies; counts occurrences).
3. *Selecting appropriate strategy* - The parent chooses a suitable behaviour change strategy and makes a specific plan that they wish to implement (e.g., behaviour contract; clear, calm requests; descriptive praise).
4. *Implementing strategy* – The parent puts the plan into action (e.g., behaviour chart is put on the fridge and filled in as behaviour occurs).
5. *Monitoring implementation of strategy* – The parent monitors the application of the new strategy making sure that each aspect is adhered to (e.g., tracking behaviours, using tally chart, rewards, and consequences).
6. *Evaluation of performance* – The parent uses self-reflection and evaluates whether they attained the changes in behaviour that they set out to achieve. If they did not reach the goal criterion, they adjust the plan by selecting a different strategy and start the process again (e.g., ask the adolescent to suggest a suitable

reward if the current one isn't motivating the adolescent to change; or begin to phase out rewards when the new behaviour is established).

7. *Self-reward* – The parent gives themselves positive feedback for achieving their goal (e.g., verbal expression, "I am doing well"; celebrate with coffee/drink; buy self a gift).
8. *Setting future goals* – The parent decides what aspects of their own behaviour and the adolescent's behaviour that they wish to change in the future (e.g., "I will praise her more often, at least three times a day"; "We will discuss cell phone use at our next family meeting").

The skills training process in the self-regulation approach to parenting is active. It uses modelling, practice, feedback and support to help the parent acquire, implement and refine new parenting techniques. Theoretically, the strategies the practitioner uses to coach and prompt the parents (during sessions 5-7) to apply the parenting skills they have learned should promote the development of parental self-management skills as well. Examples of practitioner prompts that promote self-management skills include: goal setting – "Let's review the goals and tasks you set for yourself last week"; monitoring of behaviour – "You have described some difficulties you are having with you teenager's behaviour regarding family chores, tell me how things are going this week"; selecting strategy – "What strategy have you chosen to use?"; implementing strategy – "That's great, it sounds like you have been practicing the plan"; monitoring implementation of strategy – "Well done for sticking to your plan"; evaluation of performance – "What went well with this goal? What could you have done differently?"; and setting future goals – "Let's look at your next goal".

3.6 Research Questions

The methodology chosen for this research was based on the following key research questions that the researcher sought to address:

1. Do parents actually acquire self-management skills during the Group Teen Triple P programme?
2. Does the adolescent's target behaviour, chosen by the parents, change during the Group Teen Triple P programme?

3.7 Design

The researcher only had access to small groups of people and could not therefore use a between subjects randomised control design. To answer question one, this study used an A/B (baseline/intervention) Single Case Research Design (SCRD; Cooper, Heron & Heward, 2007) to examine the effects of the GTPPP programme on changes in parental self-management competence. One baseline measure was taken and two following measures were taken to measure intervention effects, mid-intervention and post-intervention. To answer question two, a multiple-baseline across participants Single Case Research Design (SCRD; Cooper et al., 2009) was used to examine the effects of the GTPPP programme on changes in adolescent behaviour in response to application of the self-management skills by the parents. A natural multiple baseline was used as the parents, in consultation with the facilitator, decided when they would monitor their adolescent's behaviour and for how long.

A single case research design (SCRD) was chosen because the researcher wanted to do an in-depth study of parent/adolescent interactions. According to Cohen, Manion and

Morrison (2011, p 323), a single-case research strategy also offered a number of features that helped establish intervention effects. Firstly, it allowed the researcher to study the rate of change as well as the outcome by recording responses repeatedly during the different phases (i.e., baseline, intervention, and follow-up). Secondly, it allowed the researcher to look for the cause-and-effect relationship between the intervention and the behaviour by studying only one participant at a time. Thirdly, using successive replications of an intervention across participants permits confidence in the causal inferences. Fourthly, the findings were directly relevant to the specific participant (parent and/or child) and could provide data for immediate practical use. Additionally, repeated baseline measures help to establish stability of a phenomenon and by having differing lengths of multiple baselines across participants, the researcher could control for time effects.

3.8 Presentation of data in graphs and tables

The data gathered indicating the frequency of the self-management skills demonstrated by the participants, firstly, during the three family discussions (pre-intervention, mid-intervention, and post-intervention) and secondly, during the three telephone consultations (sessions 5-7) will be presented in graphs to allow for visual examination of changes in each skill used by each participant over time. This data will then be presented in tables to allow for the examination the rate of change in the use of total skills used in the family discussions and in the telephone consultations over time. Additionally, a table will be presented to show the number of skills each participant actually uses at each interval during each family discussion. The self-management skills frequencies will also be presented in tables and graphs to help analyses the pattern of how each skill developed for the group of participants as a whole.

Time-series graphs showing the AB design (Kazdin, 1982) will be used to present the target behaviour tallies, gathered by the parents during the behavioural monitoring task, to allow for visual examination of changes in level, trend and variability in adolescent behaviour in response to the strategy implemented by the parent.

3.9 Understanding Modified Brinley Plots

However, the data from the secondary measures (standard Triple P measures) were presented in modified Brinley Plots.

Modified Brinley plots (as in Stunkard & Penick, 1979; Jacobson & Truax, 1991; Sobell, Sobell, & Gavin, 1995) are scatterplots where the same measure is plotted for each individual over pairs of times. T1 is usually plotted on the X-axis, and T2 on the Y-axis. In this study, for example, stress scores were plotted for each individual participant T1 (pre-intervention) against T2 (post-intervention). If there was no change of score values from T1 to T2 and given that the axes have the same scale and origin, all individual data points will lie along the diagonal line – the line of no change. When the data points are scattered closely about the diagonal line, it indicates unsystematic sources of variability at T2. A treatment effect between T1 and T2 is evident in systematic movement of the plotted points either above or below the diagonal line, showing either improvement or deterioration for some or all participants over time. Therefore, the modified Brinley plot was used as it allowed the detection of no change, little change, improvement or deterioration over time, and individual outliers. It also helped to identify patterns of variation in effect.

To assist with the interpretation of the results, the Reliable Change Index (RCI) was included to determine if any change over time indicated clinically important change (cf Jacobson & Truax, 1991). Reliable change over time is change that exceeds the margin of measurement error defined as $\pm 1.96 S_{Diff}$, where S_{Diff} is the standard error of measurement of the difference, and ±1.96 delineates the 5% tail of the normal distribution of errors (Wise, 2004). In modified Brinley plots, for any measure, the upper and lower boundaries of the RCI can be shown on either side of and parallel to the 45^0 no-change line.

As the standard measures used to assess change in the Group Teen Triple P programme have been found to discriminate between low-risk and high-risk samples (e.g., SDQ: Goodman and Scott, 1999) and have established clinical cut-offs to discriminate between clinical and non-clinical samples (e.g., DASS: Lovibond & Lovibond, 1995), the clinical cut-off information was also added to the plot via vertical and horizontal lines placed so that they cut the axes at the designated cut-off score to help with interpretation of change over time. Additionally, an arrowhead was added to the vertical line to show which direction, increase (up arrow) or decrease (down arrow), represented improvement post-treatment. The integration of the clinical cut-off lines and the RCI dashed lines allowed the classification of each participant's outcome on the measure, as shown in Figure 2.

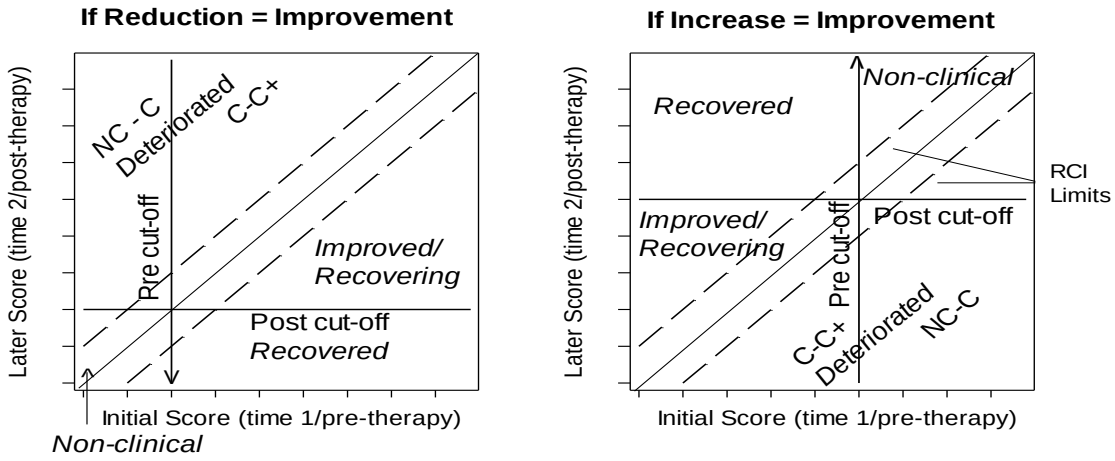

Figure 2. Templates used to demonstrate how the Reliable Change Index and clinical cut-off scores were combined to help classify an individual's change into a clinically meaningful category (based on Jacobson & Truax, 1991), (Blampied, 2015, personal communication). [C = clinical; NC – non-clinical; C+ = clinical deterioration; RCI = Reliable Change Index].

The vertical and horizontal lines show the pre and post cut-offs respectively and the arrow on the vertical line shows the direction of clinical improvement – decrease for the left graph and increase for the right graph. According to the direction (up or down) of the clinical change, the left and right graphs show the outcome classifications. The solid 45° line indicates the line of no change over time and the upper and lower bounds of the Reliable Change index are marked by parallel dashed lines. Outcome classifications were only applied when the participant's data point lay outside the RCI limits. Additionally, the graphs allowed two kinds of deterioration to be identified, one where an individual was clinical at

T1 and gets worse over time (C-C+) and the second where an individual was non-clinical at T1 and enters the clinical range at T2 (NC-C).

The following chapter describes the research methods used in this study.

CHAPTER 4

RESEARCH METHODS

4.1 Recruitment

The participants were recruited from parents/caregivers enrolled in the Group Teen Triple P programme delivered at the Pukemanu-Dovedale Centre, University of Canterbury. At the initial stage of recruitment, the principals of selected local intermediate and high schools were contacted by email, and then by a follow-up phone call, to inform them about the parenting programme and inviting the parents at their school to participate. A Group Teen Triple P flyer explaining the programme was attached to the email to be distributed throughout the schools and their communities (see Appendix B). The GTPPP Facilitator received expressions of interest via phone and/or email.

The GTPPP Facilitator then contacted each potential participant and explained what the programme offered, gave dates and times, confirmed enrolment, and asked each participant if they were interested in learning more about a research project that was running alongside the parenting programme. A letter of explanation was sent to those who showed interest (see Appendix B) and they were also asked if the student researcher might contact them. Of the 20 participants who enrolled in the GTPPP programme, 16 expressed some interest in learning more about the research and five families (four individual parents and one couple) agreed to be involved in a research study. Those who did not agree continued in the programme but did not contribute data to the project. The student researcher arranged times for pre-intervention home visits to deliver the information letter, questionnaires, and consent forms and to record the first parent/adolescent discussion.

4.2 Participants

The participants were parents of adolescents aged between 12 to 16 years of age who participated in the GTPPP programme. All participants were Pakeha (European/New Zealand decent) and the biological parents of their adolescent. Additionally, all participants' marital status was *currently married*, however only one couple attended and the other four families were represented by only one parent. All participants have been given an alphabetical title (e.g. Family A/Participant A/Adolescent A) to protect their privacy. A description of each family is as follows:

1. *Family A:* Participant A was a 41 year old mother of Adolescent A, a 12 year old boy. The mother enrolled in the course because she was concerned about of her son's moods and behaviours. On the Issues Checklist, Participant A identified two specific behaviours that made her angry (getting to school on time; and lying) and one behaviour that made her a little angry (buying CDs and books). At the initial session she expressed a lack of confidence in her ability to deal with these challenges. Additionally, the Group Teen Triple P course had been recommended to her by a family member.
2. *Family B:* Participant B was a 57 year old mother of Adolescent B, a 16 year old girl. The mother joined the course because she was concerned about her daughter's emotional problems, risky behaviours and ADHD. She wanted to be better equipped to support her daughter to make the necessary changes so that she could finish school well and be happy. On the Issues Checklist she identified three specific behaviours the made her a little angry (turning things off in the house; getting to

school on time; and coming home on time). Participant B also wanted to build a better relationship with her daughter.

3. *Family C:* Participant C was a 47 year mother of a 13 year old girl (Adolescent C). She enrolled in the programme because she was concerned about her relationship with her daughter and she also had some concerns about her daughter's emotions and behaviours. While filling out the Issues Checklist, Participant C identified two specific behaviours that made her angry (going to bed on time; and cleaning up the bedroom) and six behaviours that made her a little angry (doing homework; putting away clothes; how money is spent; getting to school on time; helping out around the house; and getting up in the morning). She stated that she wanted to find ways for them to work things out so they both were happy and could feel love towards each other.
4. *Family D:* Participant D was a 45 year old father of a 14 year old girl (Adolescent D). He chose to do the GTPPP course because he was mainly concerned with his own lack of parenting skills, especially in regards to dealing with adolescents. He wanted to be a better parent, to enhance educational outcomes for his daughter and to improve their relationship. Participant D was generally happy with his daughter's behaviour, however, in the Issues Checklist he identified that he got a little angry over three behaviours (table manners; who she should be friends with; and what time to have meals).
5. *Family E/F:* Participant E was a 46 year old mother of a 14 year old boy (Adolescent E) who had been diagnosed with dyspraxia. She wanted to do the GTPPP course because she had quite a number of concerns regarding her son's behaviours, emotions and friendships. Participant E also wanted to learn to work together with

her husband (Participant F) so that they could help their son gain skills for life and become reliable and independent. Participant E indicated that five adolescent behaviours on the Issues Checklist made her a little angry (getting to school on time; bothering parents when they want to be left alone; messing up the house; earning money away from home; and what the adolescent wanted to eat). Participant F was a 50 year old man (married to participant E), and parent of their son (Adolescent E). He was frustrated with his son's "laziness and lack of co-operation" and wanted to know what to do about it. He also wanted his wife and himself to parent more effectively together. On the Issues Checklist, Participant F identified six adolescent behaviours that made him angry (time for going to bed; getting to school on time; helping out around the home; talking back to parents; getting up in the morning; and earning money away from home) and six behaviours that made him a little angry (cleaning up bedroom; putting away clothes; using the television or computer; fighting with brothers and sisters; lying; and messing up the house).

4.3 Settings and Personnel

The GTPPP programme was held at the Pukemanu-Dovedale Centre, which is run by the University of Canterbury Child and Family Psychology Programme providing assessments and interventions for children and families/whanau. It operates as part of the professional training course for post-graduate students training in Child and Family Psychology. The trained facilitator delivering the GTPPP programme was the Centre Director and a registered clinical psychologist. The researcher was a Child and Family Psychology Master's thesis student. The researcher did not deliver the parenting programme, and remained as a

passive observer in order to minimise bias and power issues. All participants elected to be seen by the researcher at their family home to record the family discussions.

4.4 Materials

The intervention followed the *Facilitator's Manual* for Group Teen Triple P (Sanders and Ralph, 2002*).* The participants each received the *Teen Triple P Group Workbook* (Ralph and Sanders, 2004), which included session content, examples and homework exercises for their own personal use. Additional behaviour monitoring worksheets (charts, tallies, diaries, records and graphs) were also provided at the participants' request during the course of the intervention. All the resources were supplied by Triple P International and provided free of charge by the Ministry of Education and the Pukemanu-Dovedale Centre.

4.5 Measures

Data collection for this study began with a battery of standard questionnaires recommended for assessment in the *Facilitator's Manual* for Group Teen Triple P. They were administered by the GTPPP Facilitator pre and post-intervention. The following measures were included:

1. *The Family Background Questionnaire* (FBQ: Sanders & Ralph, 2002) was adapted from the Western Australian Health Survey (Zubrick et al, 1995) and supplied information relating to each family. The FBQ included questions about: the participant's contact details; the adolescent's name, gender, age and date of birth; the participant's relationship with the adolescent (e.g. mother, step-mother); and the marital status of the participant.

2. *The Issues Checklist* (Prinz, Foster. Kent and O'Leary, 1979) is a 44 item checklist that asked parents to identify the issues that they have talked about with their adolescent during the last four weeks (e.g., cleaning up bedroom; fighting with brothers and sisters; coming home on time). Parents respond to each item by circling either Yes or No. For each item marked as *yes*, parents are then instructed to rate the intensity of the discussion on a five point scale, from 1 (calm) to 5 (angry). Items with a higher intensity rating (3-5) were then brought up for discussion during the telephone consultations.
3. *The Strengths and Difficulties Questionnaire – Extended Version* (SDQ; Goodman, 1997, 1999) was used to obtain a measure of parents' perceptions of behaviours in children/adolescents aged 3 to 16 years. The SDQ included twenty-five items relating to the frequency of negative and positive behaviours (e.g., often loses temper; general liked by other children) rated on a three point scale (not true; somewhat true; certainly true). The 25 items were divided into five subscales: emotional symptoms, conduct problems, inattention/hyperactivity, peer problems; and prosocial behaviour. Scores were generated by summing the five items for each subscale (a range of 0-10). The Total Difficulties score was computed by summing the scores from the four problem behaviour scales (emotional, conduct, hyperactivity, and peer problems) which ranged from 0-40. The Australian norms for 11-13 year old boys were used to establish the severity ratings for each subscale (Mellor, 2005). The Total Difficulties score showed behaviours as normal (0-12), borderline (13-16) and abnormal (17-40). The clinical cut-off for each subscale was equal to or greater than the following scores: emotional symptoms - 5; conduct problems - 4; hyperactivity - 7; peer problems - 4; and prosocial behaviour equal to

and less than - 5. The SDQ extended version included an assessment of whether the parent perceived the child to have a problem and to what extent the problem impacted the family. The perception of problem and impact on family questions were rated on a 4-point scale (e.g., not at all; only a little; quite a lot; a great deal). The severity rating for the Total Impact score ranged from 0 (normal), 1 (borderline) to 2-10 (clinical).

4. *The Parenting Scale for Adolescents* (PS-A) was adapted by Irvine, Biglan, Smoldowski and Ary (1999) from the Parent Scale developed by Arnold, O'Leary, Wolff and Acker (1993). This 13 item scale measured the dysfunctional parenting discipline styles of laxness (inconsistent discipline, permissive), and over-reactivity (irritability, emotional authoritarian discipline, harshness), by asking parents about the probability of them using each discipline strategy. A scale ranging from 1-7 was used to rate each item. The subscale scores were then summed and compared to norms to discriminate between clinical and non-clinical levels (Arnold et al., 1993). Clinical cut-offs included: laxness 3.1; over-reactivity 3.6; and total 3.2.
5. *The Depression-Anxiety-Stress Scale* (DASS-21; Lovibond & Lovibond, 1995) was used to measure symptoms of depression, anxiety, and stress in adults. The DASS-21 was adapted from the longer DASS-42. The DASS-21 required the participants to consider the past week and respond to each of the 21 statements by selecting a number on a 4-point rating scale (0 – did not apply to me at all; 1 – applied to me to some degree, or some of the time; 2 – applied to me a considerable degree or a good part of the time; 3 – applied to me very much, or most of the time). An example of a depression statement was, "*I felt I had nothing to look forward to';* an anxiety statement, "*I had a feeling of shakiness (legs going to give way)";* and a stress statement, *"I found*

myself getting upset by quite trivial things". The scores for each scale from the DASS-21 were doubled so that a minimum score of 0 to a maximum score of 42 could be obtained and compared to the severity ratings, of normal, mild, moderate, severe and extremely severe, reported by Lovibond and Lovibond (1995).

6. *The Conflict Behaviour Questionnaire* shorter version (CBQ-20; Prinz, Foster, Kent & O'Leary, 1979; Robin & Foster, 1989) which measured the level of conflict between parent/caregiver and adolescent. There were two versions, one for the parent to fill out and one for the adolescent to fill out twice (one regarding the father and one regarding the mother).
7. *The Client Satisfaction Questionnaire* (CSQ), adapted from the Therapy Attitude Inventory developed by Eyberg (1993), assessed the quality of the programme provided. The SCQ also asked to what extent the programme met the parent's needs, improved parenting skills, and decreased problem behaviours in the adolescents. The final question asked if the participant would recommend the programme to others and provided the opportunity for general comments and suggestions. The satisfaction ratings were on a 7-point scale. Examples of anchor point descriptions for rating one were variously: *poor; definitely not; quite dissatisfied; and considerably worse*. Examples of anchor point descriptors for rating a seven were variously: excellent; *yes definitely; very satisfied; and greatly improved*. The total score ranged from a minimum of 13 to a maximum of 91.

4.6 Observation of family interaction

Three planned family discussions were conducted by the parent and adolescent and audio recorded by the researcher in the participant's home at baseline, during intervention

(between session 4 and 5), and at follow-up. The topic of discussion was either chosen from items identified in the Issues Checklist or the adolescent and parent chose a current problematic issue. The families were advised by the researcher to choose a *warm issue* rather than a *hot issue* that may cause people to get upset. The researcher coded data from these recordings in the same manner as used for the telephone consultation sessions, i.e., tracking the occurrences of the self-management skills, (see Appendix J).

4.7 Observation of telephone consultation sessions

Three semi-structured telephone consultations (Sessions 5, 6, and 7), a standard part of the programme, were conducted by the Facilitator. A digital voice recorder was attached to the telephone to record each session and parents consented to the recoding. The procedure of the call followed the format in the Facilitator's Manual. The researcher coded data from the recordings by tracking occurrences of eight identified self-management skills: goal setting; monitoring of behaviour; selecting appropriate strategy; implementing strategy; monitoring implementation of strategy; evaluation of performance; self-reward; and setting future goals (see Appendix J).

4.8 Behavioural Monitoring

Data collection for this study also included tallies from parental monitoring records that tracked changes in adolescent behaviour at baseline and during the application of a selected change strategy. The monitoring of behaviour task served two main purposes: firstly, as a validity check of the parent's perceptions of their adolescent's behaviour (nature, frequency, duration and intensity); and secondly, to provide evidence of change so that a particular behavioural strategy could be evaluated for effectiveness. Additionally, the

researcher could examine if there was a link between parental acquisition of competencies and adolescent behaviour change. The data was collected by the researcher at the second and third home visit.

4.9 Assessment Timeline

The timeline for the administration of each assessment measure is shown in Table 7.

Table 7.

Assessment Timeline

Measures	Baseline	1	2	3	4	5	6	7	8	Follow Up
Triple P Questionnaire	✓									✓
Family Discussions	✓				✓					✓
Telephone consultations						✓	✓	✓		
Behavioural monitoring					✓					✓

Weeks

The research was supervised by a registered clinical psychologist, who was an Associate Professor of Child and Family Psychology (School of Health Sciences), and a registered psychologist, who was a Professor of Psychology (Department of Psychology), at the University of Canterbury.

4.10 Intervention

The intervention was in the form of four group parenting workshops, three individual telephone consultations, and one final group review session. The standard Group

Teen Triple P – Positive Parenting Programme was delivered by the Centre Director. Verbal instructions, video scenarios, written material, guided exercises, and homework tasks were provided. The topics covered in the group sessions (1-4) included positive parenting, encouraging positive behaviour, managing problem behaviour, and dealing with risky behaviour. The self-management skills were also introduced during these four sessions. The three telephone consultations (sessions 5-7) focussed on implementing parenting routines for each family. These sessions were designed to embed the self-management skills that were taught in the first four sessions. The participants were guided through the process (i.e., in using the self-management skills) as they applied the selected strategies to achieve desired behaviour changes in their adolescents. The final session (eight) was held with the whole group and focussed on reviewing and evaluating each family's progress, survival tips, maintaining changes, and future problem solving.

4.11 Procedure

Baseline. The researcher contacted the participants who had agreed to take part in this study prior to the start of the intervention to establish a time to have the initial meeting. At the initial meeting, the researcher met with the participants in their home to establish a friendly working relationship, explain the research, answer any questions, collect the completed consent forms, and voice record the first family interaction. Before the researcher left, a time was agreed upon for the next family interaction session. Initial completion of the Triple P standard questionnaires (baseline assessment) was done prior to the first session and given to the facilitator on arrival. Baseline target adolescent behaviour tallies were taken by the parents, as they decided naturally when they would monitor and for how long.

Training. The participants then completed the eight week Group Teen Triple P programme, knowing there would be a second recorded family discussion and a check of the behaviour diary after session four. Additionally, the parents were aware that their telephone consultation in sessions 5-7 would be recorded for analysis.

Post-training assessment. The final completion of the Triple P questionnaires was done following the last training session. The last family interaction was recorded post-intervention (1-2 weeks later) at the participant's home. At the last family visit, the researcher also collected the Triple P questionnaires, the behavioural monitoring diaries and/or the frequency tallies completed by the parents. At the end of the final family visit, families were asked about their experiences with the programme, the strategies they found most effective and their perception of changes in the family after the intervention.

4.12 Ethical Considerations

Prior to the research commencing, the researcher gathered informed consent from the GTPPP Facilitator, participating parents and their teenagers to collect data in the manner described above (see Appendices G-I). Ethical approval from the University of Canterbury's Educational Research Human Ethics Committee (ERHEC) was obtained for the study to take place (see appendix). The right to withdraw from the study at any time was granted. The participants were known to the researcher, however their personal details were protected in the reporting of data and to third parties. For discussion purposes the researcher's supervisor was aware of the family groups chosen for the project. Confidentiality of information gathered and transcripts of recorded data was guaranteed. If some of the families from other cultural backgrounds were involved in the project the researcher would check with her supervisor about the appropriate procedures. Had there

been any Maori families, Dr Sonja McFarlane agreed to act as cultural consultant if required. If parents had difficulty applying the skills taught in the programme, they would receive support from the Facilitator and referral to their family doctor, counsellor or appropriate agency. The researcher followed the Health and Safety guidelines for students involved in field visits and the researcher also consulted with the supervisor regarding protocols to follow.

The following chapter presents the results of the self-management skills coded data collected during the family discussions (pre-intervention, mid-intervention, and post-intervention) and the telephone consultations (sessions 5-7); the multiple-baseline recordings of adolescent behaviour change; the secondary out-come measures; and the family feedback.

CHAPTER FIVE

RESULTS

5.1 Scoring and Data Analysis

The coding reports of each recorded telephone consultation and each recorded family discussion were collated, checked for inter-rater reliability, and presented in graphs to allow for the examination of acquisition of competencies at each interval (Time 1, Time 2 and Time 3). Tables of data showing frequency of self-management skills demonstrated for each participant and each variable over time and means and standard deviations for the group were also generated. The daily behaviour diary scores were collected and presented in time series graphs (for each adolescent) to allow for visual examination of changes in behaviour levels, trends, and variability. The data collected from each completed Triple-P questionnaire was presented in modified Brinley plots (Blampied, 2014) to allow for the examination of the differences between pre-test and post-test scores. Attention was focussed on the movement of scores in comparison to the clinical cut-offs in each measure.

5.2 Behavioural Monitoring

In order to examine the effectiveness of the intervention on adolescent behaviour and to answer the second research question, “Does the adolescent’s target behaviour, chosen by the parents, change during the Group Teen Triple P programme?”, the target behaviour tallies gathered from the parents were examined first. Only four families supplied data as one participant chose not to complete the behaviour diary or frequency tallies. All four participants kept daily records from baseline through intervention to monitor the effect of their selected strategy on a targeted adolescent behaviour.

Figure 3 presents the multiple-baseline recordings of adolescent behaviour change that were generated using the targeted behaviour tallies.

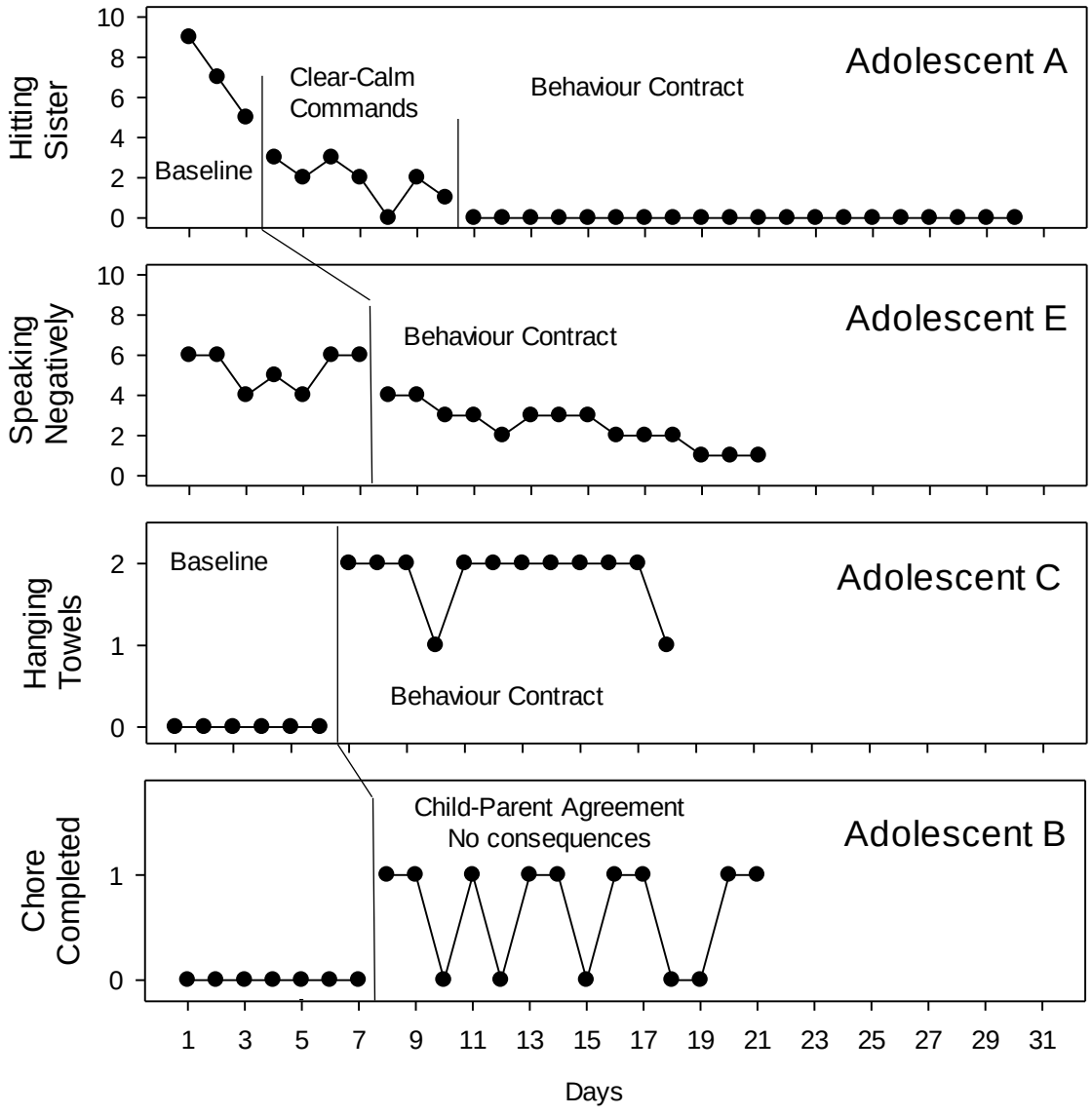

Figure 3. Time-series graphs showing adolescent behaviour change.

The goal for Adolescent A (12 year old boy) was to decrease the behaviour of hitting his sister. At baseline recording there was a downward trend over three days (range 9-5, mean 7). A strategy of clear-calm commands was implemented after day three. The chosen strategy involved the clear, calm command of, “Hitting is not ok. Please stop”. The hitting behaviour decreased at a steadily over the next seven days, however scores showed some variability (range 0-3, mean 1.6). The second strategy implemented, a behaviour contract, was introduced after day 10. The contract involved a reward, selected by the adolescent (a new book), if his chart showed no hitting for one week. The behaviour dropped immediately to zero for days 11 to 21. The adolescent received his prize after a week and continued the no hitting behaviour for the following two weeks. No reward was offered during this time.

Participant E and F (married couple) targeted their 14 year old son’s behaviour of speaking negatively. Daily baseline recordings over seven days showed fairly stable levels (range 4-6, mean 5.3). A behaviour change strategy was implemented after day seven. The behaviour contract offered a reward of extra play-station time for not speaking negatively and a consequence of loss of play-station time for speaking negatively. The targeted behaviour levels decreased to an average of 3.1 over the next seven days and further decreased in levels the following week to an average of 1.7.

Participant C wanted her 13 year old daughter (Adolescent C) to hang up her wet towel after morning and night time showers (two showers per day). A six day baseline showed that no wet towels were hung up on any day. A behaviour contract was implemented after day six. The mother offered to give her daughter a ride to school on the days she hung up her wet towels, otherwise the adolescent had to walk. The behaviour

tallies showed the Adolescent C hung up the wet towels twice a day for 10 days out of the next 12 days and once a day for the remaining two days.

Participant B wanted her 16 year old girl to complete her daily chore of unloading the dishwasher. The baseline showed that Adolescent B didn't complete her chore on any of the seven baseline days. After the seventh day, Participant B talked with Adolescent B about unloading the dishwasher and they came to an agreement that this would be done. No reward or consequence was put in place. Although there was an increase in chore completion behaviour, the daily behaviour tallies were variable and showed that Adolescent B completed her chore nine days out of the next 14 days (64% of the time).

In summary, positive changes in adolescent behaviour levels, rates and consistency were demonstrated in families where the behaviour contract was implemented. Conversely, some positive changes in adolescent behaviour but patterns of inconsistency was demonstrated where no behaviours contract was used

5.3 Transfer of self-management skills to family context

In order to answer the first research question, "Do parents actually acquire self-management skills during the Group Teen Triple P programme?", the second measure to be examined was the coded data from the three family discussions. This data also showed what self-management skills were demonstrated at baseline, at mid-intervention and by post-intervention. The inter-rater reliability score, generated by dividing the number of actual agreements by the number of possible agreements, between two raters, for the coded data tallies was 86%. Figure 4 presents the frequency tallies of each skill used by each participant over time.

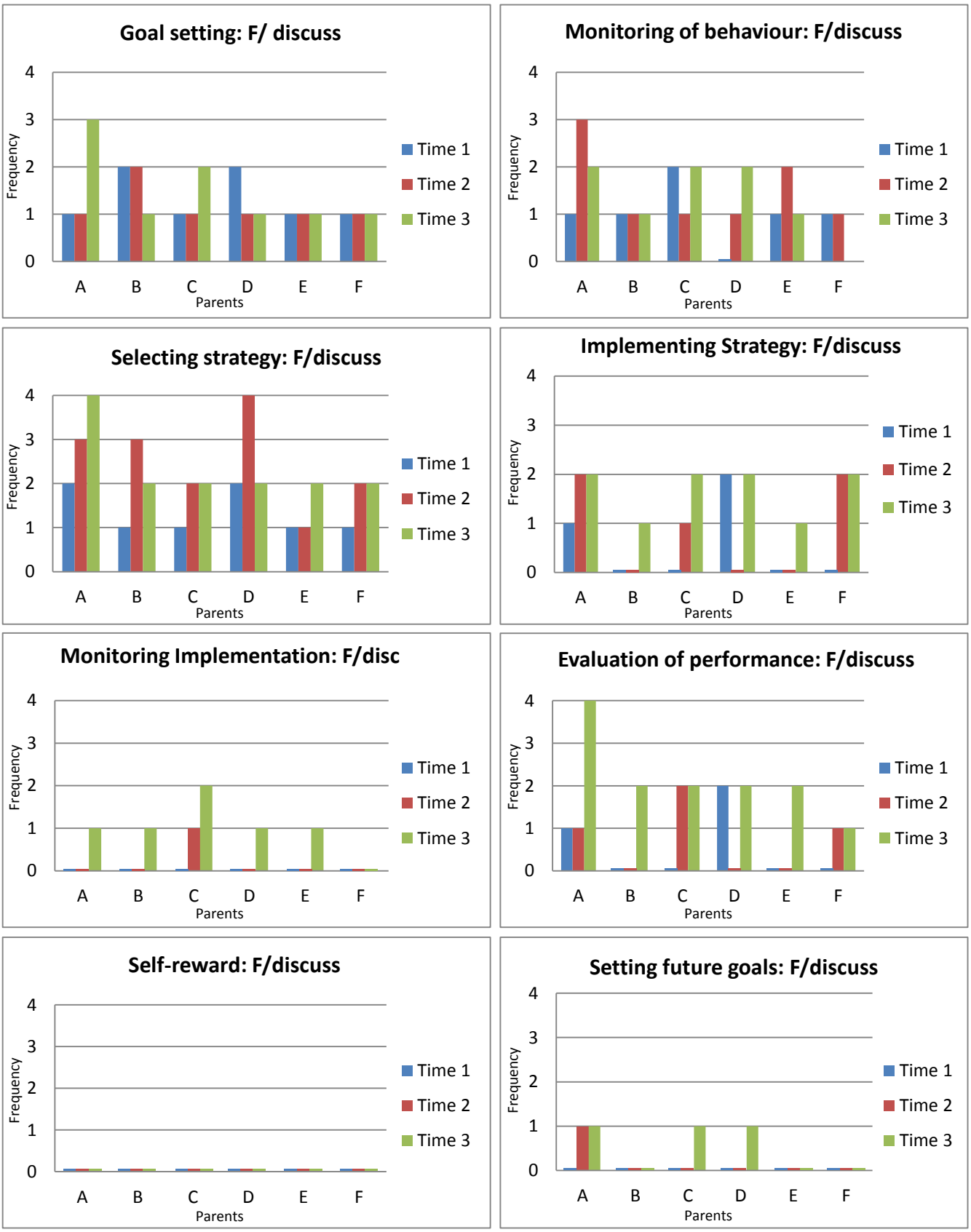

Figure 5. Frequency of self-management skills used by participants during the three family discussions.

Participant A's data showed an increasing use of a number of self-management skills over time, demonstrating five self-management skills, 1-2 times each, at base line (goal setting, monitoring of behaviour, selecting appropriate strategy, implementing strategy and evaluation of performance). Six skills were used, 1-3 times each, in the second discussion (including setting future goals) and seven skills were used, 1-4 times each, in the third discussion (including monitoring of implementation of strategy).

Participant B's data demonstrated an increase in skill acquisition between Time 2 and Time 3. Participant B used three self-management skills, 1-3 times each, at baseline and during the second family discussions (goal setting, monitoring of behaviour and selecting appropriate strategy). At discussion three, Participant B demonstrated six skills, 1-2 times each, (including implementing strategy, monitoring implementation of strategy and evaluation of performance).

Participant C demonstrated an increase in number of skills used over time. She used three self-management skills, 1-2 times each, at baseline (goal setting, monitoring of behaviour and selecting appropriate strategy), six skills, 1-2 times each, at the second discussion (including implementing strategy, monitoring implementation of strategy and evaluation of performance), and seven skills, 1-2 times each, at the third discussion (including setting future goals).

Participant D showed a decline in skills used between Time 1 and Time 2 and an increase in self-management skills used at Time 3. Participant D demonstrated four skills, twice each, at baseline (goal setting, selecting appropriate strategy, implementing strategy and evaluation of performance). At Time 2, Participant D demonstrated only three skills, 1-4 times each (goal setting, monitoring of behaviour, and selecting appropriate strategies).

However, in the third discussion, he used seven self-management skills, 1-2 times each (including monitoring implementation of strategy, evaluation of performance, and setting future goals).

Participant E's data showed an increase in the number of self-management skills acquired between Time 2 and Time 3. Participant E used three skills, 1-2 times each, at baseline and during the second discussion (goal setting, monitoring of behaviour, and selecting appropriate strategy). In the third discussion, Participant E demonstrated six skills, 1-2 times each (including implementing strategy, monitoring implementation of strategy and evaluation of performance).

Participant F's results showed an increase in self-management skills used between Time 1 and Time 2, and a decrease in skills used at Time 3. Participant F used three skills, once each, at baseline (goal setting, monitoring of behaviour, and selecting appropriate strategy) and five skills, 1-2 times each, in the second discussion (including implementing strategy and evaluation of performance). In the third discussion, he used four skills 1-2 times each (excluding monitoring of behaviour).

As the acquisition and use of each skill is considered important for the purposes of this study, the researcher decided to next analyse the presence of the eight skills, rather than the frequency of each skill, in the family discussions at Time 1, Time 2 and Time 3.

Table 8 presents the data for the number (out of a total of eight) of the self-management skills demonstrated in each of the three family discussions (pre-intervention; during intervention; and post-intervention), including the mean and standard deviation, for

each participant. Group totals, group mean and group standard deviation were also calculated.

Table 8.

The identification of the number self-management skills demonstrated by each participant, in each of the three family discussions, plus individual means and standards, including group totals, mean and standard deviation.

Participant	Time 1	Time 2	Time 3	Mean	SD
Parent A	5	6	7	6	1
Parent B	3	3	6	4	1.73
Parent C	3	6	7	5.33	2.08
Parent D	4	3	7	4.67	2.08
Parent E	3	3	6	4	1.73
Parent F	3	5	4	4	1
Group Totals	21	26	37	28	8.19

The group totals show an increase in the use of self-management skill acquisition over time. The group totals showed an increase in skills used from pre-intervention to post-intervention by 16 skills. The highest rate of increase happened between Time 2 and Time 3 as the group total increased by five skills between T/1 and T/2, and increased by 11 skills

between T/2 and T/3. This pattern of increase from T/1 to T/2, and T/2 to T/3, was consistent with the increase in self-management skills for the individuals, Participants A and C, while Participants B, D and E showed increase from T/1 to T/3. Participant F showed increase of skills used from T/1 to T/2, with a small decrease at Time 3.

5.4 Acquisition of self-management skills during telephone consultations

Additionally, in order to answer the first research question, "Do parents actually acquire self-management skills during the Group Teen Triple P programme?", the second set of data to be examined was the coded data from the three telephone consultations (sessions 5-8). This data also tested the idea that the strategies the facilitator used to coach the parents to implement the behaviour change strategies would prompt them to use the self-management skills. The inter-rater reliability score for the coded data tallies was 94%. Figure 5 presents the frequency tallies of each self-management skill used by each participant over time.

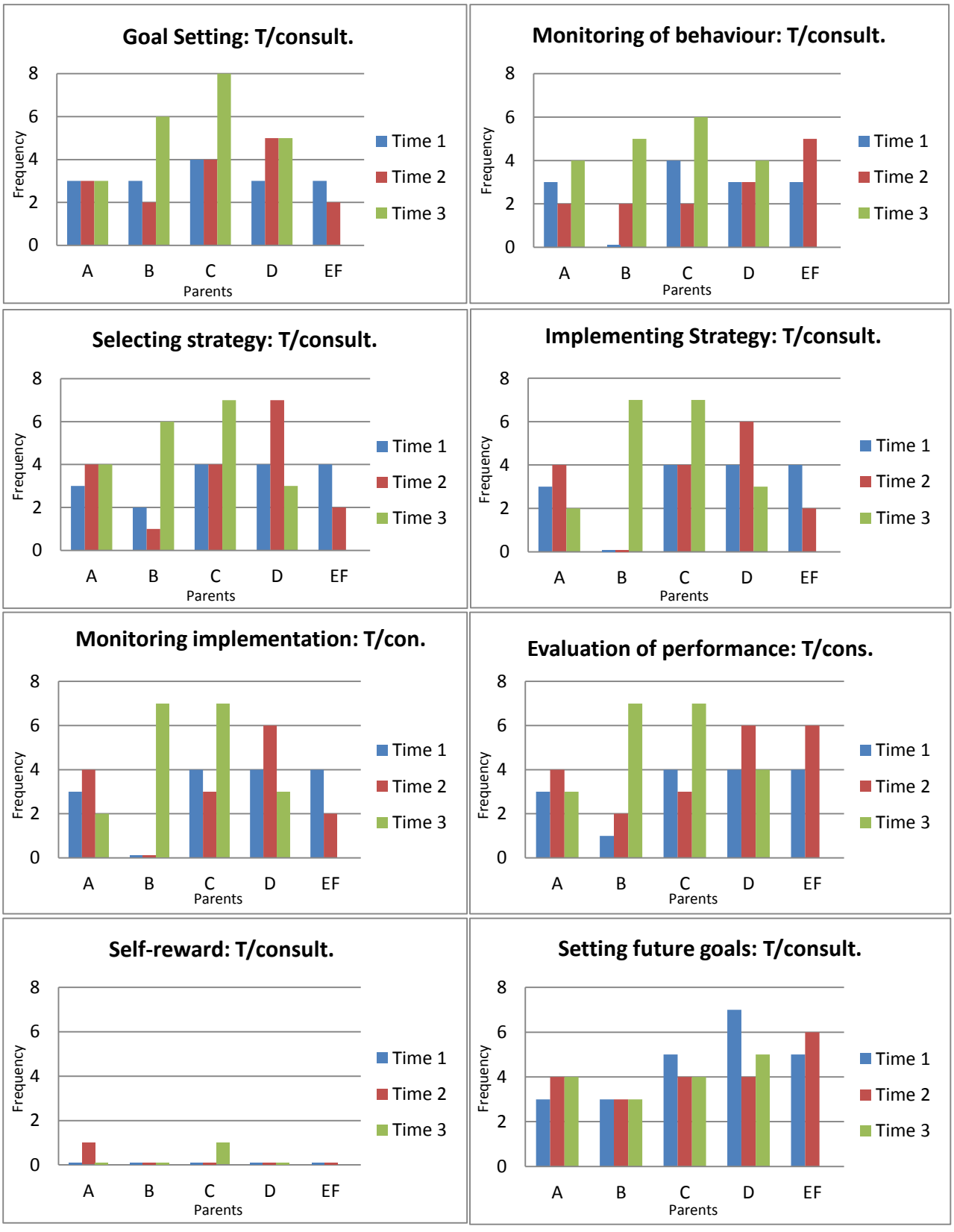

Figure 5. Frequency of self-management skills used by participants during the three telephone consultations.

The frequency of the self-management skills demonstrated during the three telephone consultations (sessions 5-7) showed that seven of the eight skills were acquired by all participants. The skill of self-reward was evident on only two occasions, once for Participant A and once for Participant C. Self-reward was not demonstrated by Participants B, D and EF.

Participant A (mother): prior to the telephone consultations, she had already demonstrated the use of six self-management skills by mid-intervention. During the telephone consultations she consistently used seven of the skills between 2-4 times during each consultation and the eighth skill (self-reward) only once. Participant A's rate of skill usage was stable over time, with a slight increase during consultation two.

Participant B (mother): had demonstrated only three skills prior to the mid-intervention family discussion and displayed the slowest rate of skill acquisition during the consultations compared to the other participants. Although goal setting, selecting an appropriate strategy, and setting future goals were spoken about (at the prompting of the facilitator) during the consultations one and two, evidence for use of the other skills was either lacking or minimal until the third telephone consultation. During the third consultation, Participant B showed a sudden increase of skill usage for six of the eight skills: goal setting; monitoring of behaviour; selecting appropriate strategy; implementing strategy; monitoring implementation of strategy; and evaluation of performance. Setting future goals was consistently evident at three per session, but self-reward was not used at all.

Participant C (mother): already showed evidence for the acquisition of six self-management skills prior to the telephone consultations. During the consultations, seven of

the skills were consistently used, with a sudden increase in skill occurrence in consultation three, where she demonstrated that she had established and maintained all her goals and strategies over the last three weeks and expressed her intention to maintain them in the future. Participant C demonstrated the use of the eighth skill (self-reward) only once.

Participant D (father): had already used four self-management skills by mid-intervention and demonstrated the use of seven self-management skills (self-reward was not apparent) throughout the telephone consultations. He consistently displayed the use of each skill between 3-7 times per consultation, with his highest rate of skill usage in consultation two for: selecting appropriate strategy; implementing strategy; monitoring implementation of strategy; and evaluation of performance.

Participants E and F (married couple): the mother had demonstrated three self-management skills, and the father had demonstrated five skills, prior to the consultations. During the telephone consultations they both displayed the consistent use of seven of the self-management skills and the lack of use of the self-reward skill. Each skill demonstrated was evident between 2-6 times over consultation one and two. No data was available for consultation three as they were absent due to a family commitment.

There was an increase in the over-all skill acquisition rate for the group of participants over time. Data showed that the self-management skills were demonstrated during each telephone consultation at an average of: 23.40 (SD 8.88) at Time 1; 24.40 (SD 9.69) at Time 2; and 34.25 (SD 11.70) at Time 3. There was an increase of skills used from Time 1 to Time 3 by 11.10 occurrences. The standard deviation also increased over time from Time 1 to Time 3 by 2.82 occurrences. The over-all mean for rate of occurrence of all skills per session for all participants was 26.80 (SD 5.72).

Table 9 presents the coded data for the total self-management skills used in each of the three telephone consultations (Sessions, 5, 6 and 7), including the mean and standard deviation, for each participant.

Table 9.

Total skills used in each telephone consultation over time for each participant

Participant	Time 1	Time 2	Time 3	Mean	SD
Parent A	21	26	22	23	2.65
Parent B	9	10	41	20	18.19
Parent C	31	24	47	34	11.79
Parent D	29	37	27	31	5.29
Parents E/F	27	25	-	26	1.41
Group Totals	117	122	137*		
Imputed score			163#		

*Data missing for Parents E/F at Time 3

#Imputed score for missing data by averaging the two previous scores for Parents E/F

The group averages showed an increase of skills being demonstrated by the group over time. Because of missing data, a true group total could not be generated at Time 3 however, by adding the E/F mean score, an indication of a probable score was produced.

Participant A showed stable levels in use of total skills over each session. Although her average skill usage was 3.80 below the group mean, she showed less variation over time.

Participant B showed the lowest skill acquisition rate overall and an unusual increase in scores at Time 3. Her mean score was 6.80 below the group average and the variance over time was the highest in the group of participants.

Participant C showed the highest average use of skills overall, however her skill use was variable as she had the second highest SD in the group.

Participant D showed consistently higher rates of skills usage and maintained an average rate higher than the group mean. Participant D also showed reduced variability in use.

Participants E and F showed that their skill acquisition rate was stable over the two telephone sessions that they were able to attend. Their average score was consistent with the group mean and they had the lowest variability of all participants.

5.5 Self-management skills analysis

The data from the family discussions and the telephone consultations was examined to analyse the pattern of skill development for the group of participants as a whole over time (e.g., What skills did the participants have before the intervention? What skills did they acquire? When did change occur?). This analysis was considered important as it investigated the frequency of use for each individual self-management skill by the parents in two

different contexts. The first context, the family discussion, was a natural family situation, and provided data from baseline, to mid-intervention (after the four group sessions) and post intervention (after the three telephone consultations). The second context, the telephone consultations with GTPPP practitioner, was part of the GTPPP parenting intervention, and occurred in the second half of the programme.

Family discussions

The family discussion data was examined to find the frequency at which the parents transferred each self-management skill to a real-life family context over time. The total skills used during each interval was also examined to see the rate of change.

Table 10 presents the total frequency of each self-management skill used in the family discussions averaged over the parents for each time.

Table 10.

Total frequency of each self-management skill used in the family discussions averaged over the parents for each time (SD)

Skill	Time 1	Time 2	Time 3
Goal Setting	1.33 (0.52)	1.67 (0.41)	1.50 (0.84)
Monitoring behaviour	1.00 (0.63)	1.67 (0.82)	1.17 (0.75)
Selecting Strategy	1.33 (0.52)	2.50 (1.05)	2.33 (0.87)
Implementing strategy	0.50 (0.84)	0.83 (0.98)	1.67 (0.52)
Monitoring implementation	0.00	0.17 (0.14)	1.00 (0.63)
Evaluating performance	0.50 (0.84)	0.67 (0.82)	2.17 (0.98)
Self-reward	0.00	0.00	0.00
Setting future goals	0.00	0.17 (0.41)	0.50 (0.55)
Total skills group mean	4.67 (1.9)	7.17 (2.32)	10.33

The summary of the use of each self-management skill over time is as follows:

1. *Goal setting* was evident before the parenting intervention (GTPPP) and maintained consistent levels of use over time.

2. *Monitoring of behaviour* was also evident before the parenting intervention. Levels of use increased at Time 2 (from 6 to 10) and dropped to seven at Time 3, however, levels did not drop back to Time 1 score.
3. *Selecting appropriate strategy* was a skill used by all participants before the intervention, however, the number of strategies selected increased from 8 to 15 at Time 2 and remained consistent at Time 3.
4. *Implementing strategy* was a skill used by only two participants at Time 1 and three participants at Time 2. By Time 3 all participants had demonstrated this skill at least once or twice.
5. *Monitoring implementation of strategy* was not demonstrated at Time 1 and only one participant used it at Time 2. By Time 3, five out of six participants showed that they were using this skill.
6. *Self-reward* was not evident in any of the family discussions over time
7. *Setting future goals* was not used in Time 1, used by only one participant in Time 2, and demonstrated by three participants at Time 3.

The total skills used by the group of participants during each family discussion was examined to measure the effect of the first four group sessions on skill acquisition (Time 2) and the effect of the telephone sessions on skill acquisition (Time 3).

Figure 6 presents the total skills used by all participants during family discussions at Time 1 (pre-intervention), Time 2 (after session four), and at Time 3 (post-intervention).

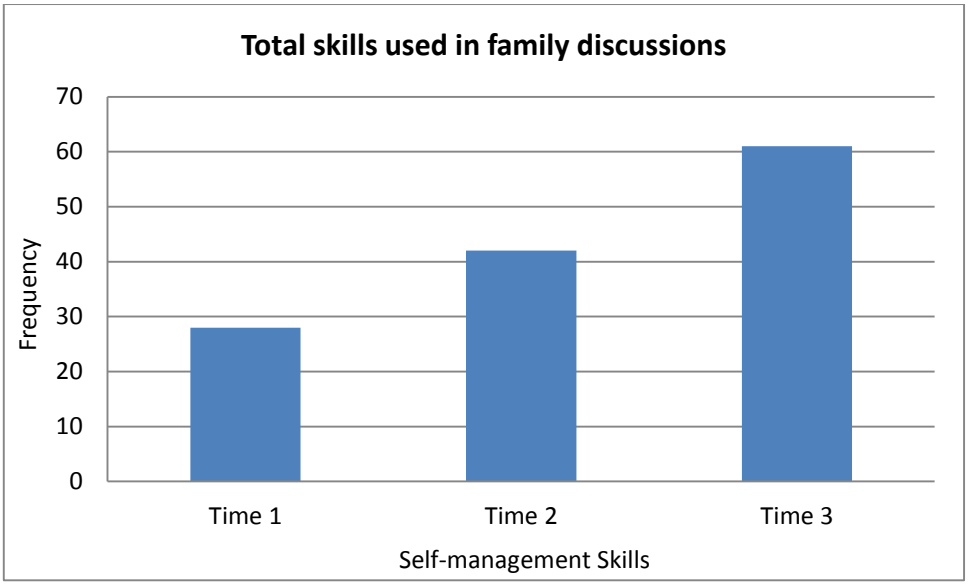

Figure 6. Total skills used by participants in family discussions over time.

The overall totals of the self-management skills used by all the participants showed an increase over time, with the largest increase between Time 2 and Time 3.

Telephone consultations

The following data examines the demonstration of each skill and the total skills used in each session for the telephone consultations. (The participants had already demonstrated an increase in self-management skills from baseline to mid-intervention during the family discussions.)

Table 11 shows the total frequency of each self-management skill used in the telephone consultations averaged over the parents for each time.

Table 11.

Total frequency of each self-management skill used in telephone consultations averaged over the parents for each time (SD)

Skill	Time 1	Time 2	Time 3
Goal setting	3.20 (0.45)	3.20 (1.30)	5.50 (2.08)
Monitoring behaviour	2.60 (1.52)	2.80 (1.30)	5.75 (0.96)
Selecting strategy	3.40 (0.89)	3.60 (2.30)	5.00 (1.83)
Implementing strategy	3.00 (1.73)	3.20 (2.28)	4.75 (2.63)
Monitoring implementation	3.00 (1.73)	3.00 (2.24)	4.75 (2.63)
Evaluating performance	3.20 (1.30)	4.20 (1.79)	5.25 (2.06)
Self-reward	0.00	0.20 (0.45)	0.25 (0.50)
Setting future goals	4.60 (1.67)	4.20 (1.10)	4.00 (0.82)
Total skills mean	23.40 (8.88)	24.40 (9.61)	34.25 (11.70)

During the three telephone consultations (sessions 5-7 of the intervention), seven of the eight skills were consistently demonstrated by the participants under the guidance of the GTPPP facilitator. The frequency of each skill being used increased over time, except for setting future goals, which showed a very small decrease. The skill of self-reward only occurred twice, once at Time 2 and once at Time 3. The mean of total skills used was fairly

consistent between Time 1 and Time 2, but showed an increase of 9.85 self-management skills used between Time 2 and Time 3.

Figure 7 presents the total skills used by all participants during the telephone consultations at Time 1 (Session 5), Time 2 (Session 6), and Time 3 (Session 7). (N.B., Time 3 total included the imputed missing data averaged from the two previous scores for participants E/F).

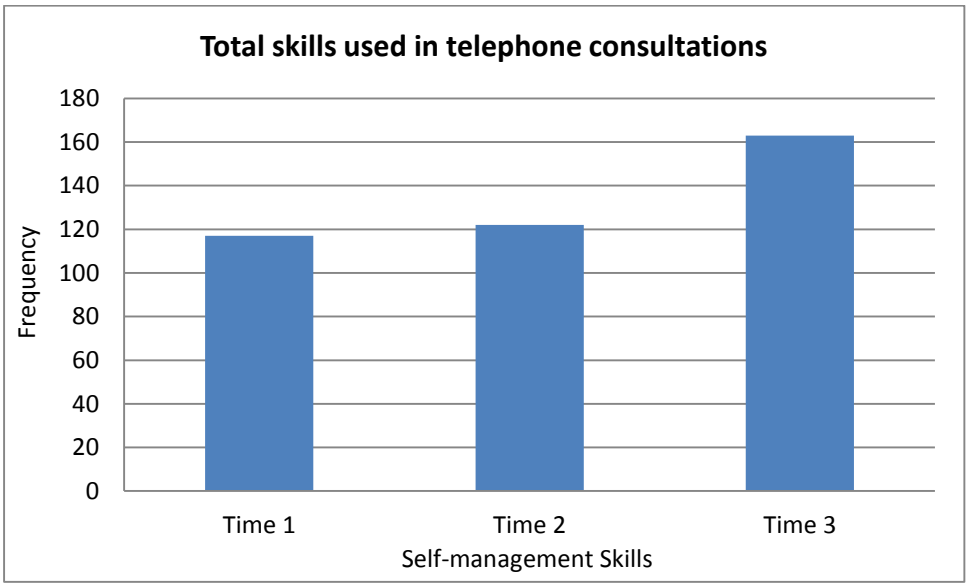

Figure 7. Total skills used by participants in telephone consultations over time

The overall totals of the combined self-management skills used by the participants showed an increase over time, with the largest increase between Time 2 and Time 3.

5.6 Secondary Outcome Measures

The standard Triple P questionnaires pre-intervention and post-intervention scores were examined to investigate the effect of the GTPPP programme on the parents' perceptions of their adolescent's behaviour; on dysfunctional parenting disciplines styles; parental symptoms of depression, anxiety and stress; and on parent and adolescent perceptions of level of relationship conflict.

The Strengths and Difficulties Questionnaire – Extended Version (SDQ: Goodman, 1997, 1999) was examined for changes in parent's perceptions of their adolescent's difficult behaviours and prosocial behaviours.

Figure 8 presents the SDQ data displayed in modified Brinley Plots to show changes in scores for each scale (emotional problems; peer problems; conduct problems; hyperactivity; prosocial behaviour; and total difficulties) from pre-intervention to post-intervention. The Australian norms (Mellor, 2005) have been used to indicate the clinical cut-offs.

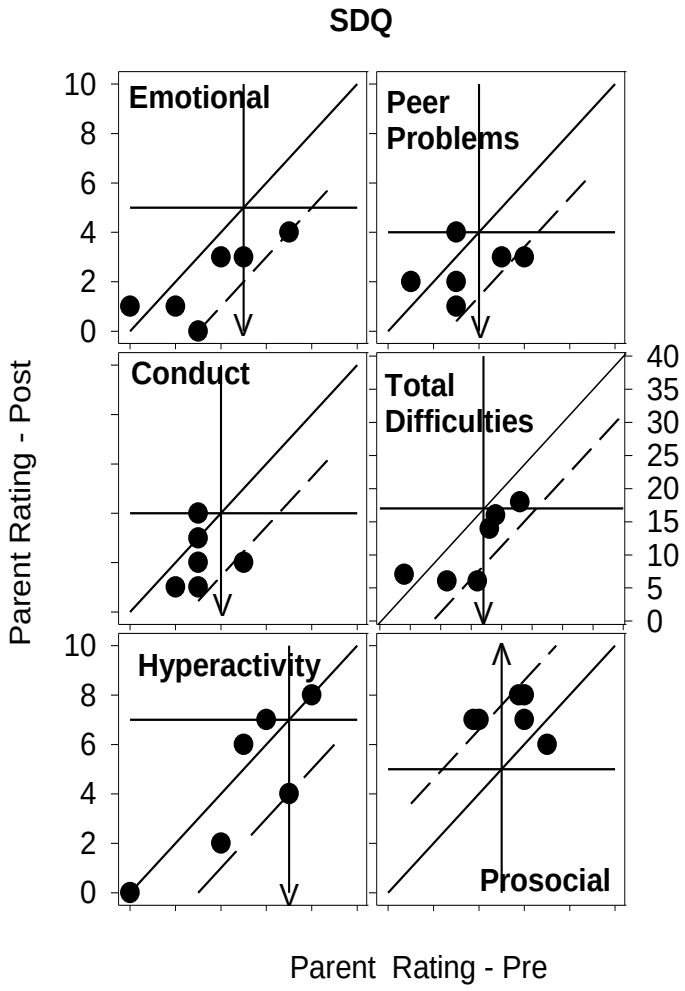

Figure 8. SDQ data showing changes in scores from pre-intervention to post-intervention (the 45° diagonal line indicates no change).

Initially, the subscales were analysed by examining the participant's scores as a group. The following results were found:

Emotional symptoms: two data points showed borderline improvement, one score improved within the non-clinical range and one score moved from the clinical range to the borderline range. Although some improvement was shown in three of the four remaining

data points over time, the change did not reach the RCI and could not be considered as reliable change.

Conduct problems: one data point showed borderline improvement by moving from the clinical range at Time 1 to the non-clinical range at Time 2. Three of the remaining five data points showed some improvement from Time 1 to Time 2 but this was not considered reliable.

Hyperactivity: one data point showed borderline change and moved from the clinical range at Time 1 to the non-clinical range at Time 2. Five data points showed no reliable change from Time 1 to Time 2

Peer problems: one data point showed borderline improvement by moving from the clinical range at Time 1 to the borderline range at Time 2. The remaining five data points showed no reliable change from Time 1 to Time 2.

Prosocial behaviours: four data points showed borderline improvement over time, two scores improved within the non-clinical range and two improved by moving from the clinical to non-clinical range. Two data points showed no reliable change from Time 1 to Time 2.

Total difficulties: one data point showed borderline improvement by moving from the borderline range to the non-clinical range. Five data points showed no reliable change over time.

Total impact: these scores are not on the figure above, however, the results are as follows: two data points were in the normal range and showed no change; one data point moved from abnormal to normal (4-0); one data point showed improvement within the

abnormal range (7-3); and two data points showed an increase in impact within the abnormal range (2-8, 2-9).

Secondly, the scores were analysed by examining the changes for each participant. The results are as follows:

Participant A: No reliable change was found in any of the measures. However, scores showed a slight worsening over time for five scales (emotional symptoms – within the normal range; conduct problems – borderline to abnormal; peer problems – within the normal range; and total difficulties – within the normal range). The total impact score improved slightly (borderline to normal) and the hyperactivity score was unchanged at 0.

Participant B: borderline improvement was found in three scales (emotional symptoms – abnormal to borderline; conduct problems – abnormal to normal; and prosocial behaviour – within the normal range). The hyperactivity score showed no change at 8 (abnormal) and the remaining measures showed no reliable change (total difficulties – within the abnormal range; total impact – within the abnormal range; and the peer problems worsened slightly from borderline to abnormal).

Participant C: four scales showed borderline improvement (emotional symptoms – normal range; hyperactivity – abnormal to normal; prosocial behaviour – normal range; and total difficulties – borderline to normal). Two scales showed some improvement but it was not considered reliable change (conduct problems – borderline to normal; and peer problems – borderline to normal) The total impact score remained unchanged at 0 (normal).

Participant D: only one scale showed borderline improvement (prosocial behaviours – abnormal to normal). The remaining scales all showed some improvement but it was not considered as reliable change (emotional symptoms – normal range; conduct problems – normal range; hyperactivity – normal range; peer problems - borderline to normal; total impact - abnormal to normal; and total difficulties – within the normal range).

Participant E: two scales showed borderline improvement (peer problems – abnormal to borderline; and prosocial behaviours – abnormal to normal). Three scales showed some improvement but it was not considered reliable change (emotional symptoms – borderline to normal; conduct problems – borderline to normal; and total difficulties – abnormal to borderline). Scores in two scales showed some worsening, however it was not considered reliable change (hyperactivity - normal to borderline; and total impact - within the abnormal score range).

Participant F: no reliable change was detected in any scale between Time 1 and Time 2. However, some improvement was found in four scales although it was considered unreliable (emotional symptoms – abnormal to borderline; peer problems – abnormal to borderline; prosocial behaviour – within normal range; and total difficulties – abnormal to borderline). Conduct problems scores were unchanged at 3 (borderline) and total impact scores worsened within the abnormal range (2-9).

The Parenting Scale for Adolescents (PSA) (Irvine, Biglan, Smolkowski and Ary, 1999) data was examined for changes in the participant's perceptions of two dysfunctional parenting styles (laxness – permissive discipline; and over-reactivity – authoritarian discipline,

including expressions of anger, meanness and irritability) from pre-intervention to post-intervention. A total score for dysfunctional discipline was also examined.

Figure 9 presents the PSA data displayed in Modified Brinley Plots to show changes in scores from pre-intervention to post-intervention.

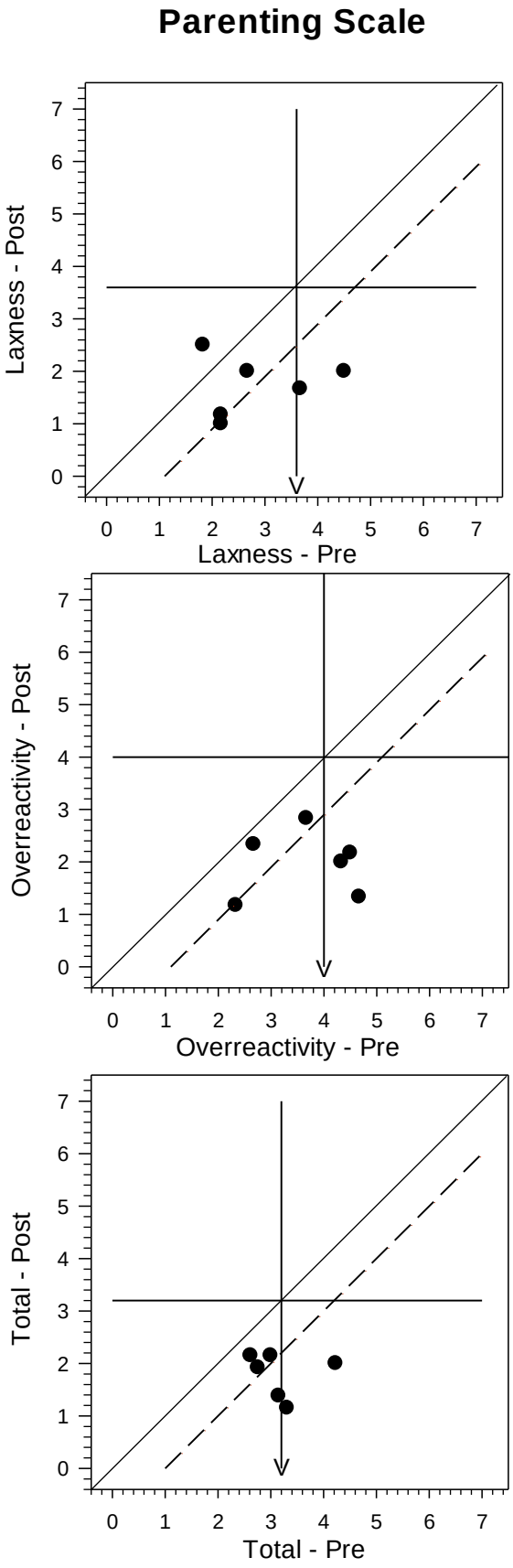

Figure 9. PSA data showing changes in scores from pre-intervention to post-intervention.

Firstly, the subscales were analysed by examining the participant's scores as a group. The following results were found:

Laxness: two data points showed reliable improvement and moved from the clinical range to the non-clinical range; two data points showed borderline improvement within the non-clinical range; and two scores showed no reliable change within the non-clinical range.

Over-reactivity: three data points showed reliable improvement and moved from the clinical range to the non-clinical range; one data points showed borderline improvement within the non-clinical range; and two scores showed no reliable change.

Total score: three data points showed reliable improvement over time (two scores moved from the clinical range to the non-clinical range and one score moved from the borderline range to the non-clinical range); the three remaining data points showed some improvement, however it was not considered reliable change.

Secondly, the scores were analysed by examining the changes for each participant. The results are as follows:

Participant A: no reliable was found over time for all data points, however each score showed some improvement within the non-clinical range.

Participant B: reliable improvement was found in laxness (clinical to non-clinical range) and total score (borderline to non-clinical range); borderline improvement was found in the over-reactivity score (within the non-clinical range).

Participant C: reliable improvement was found in all three scales (laxness, over-reactivity, and total). All data points moved from the clinical range to the non-clinical range.

Participant D: two scales showed reliable change over time and moved from the clinical range to the non-clinical range (over-reactivity and total score). The laxness score showed borderline improvement within the non-clinical range.

Participant E: borderline improvement was found in the laxness scores over time (within the non-clinical range); improvement was found in the over-reactivity score (clinical range to the non-clinical range) and the total score (within the non-clinical range) however, it was not considered reliable change.

Participant F: the over-reactivity scale score showed reliable improvement over time (moving from the clinical range to the non-clinical range); the total score improved within the non-clinical range and the laxness score worsened slightly within the non-clinical range, however both scores did not show reliable change.

The Depression-Anxiety-Stress Scales (DASS) (Lovibond and Lovebond, 1995) data was examined for changes in the participant's perceptions of their personal symptoms of depression, anxiety, and stress.

Figure 10 presents the DASS data displayed in modified Brinley Plots to show changes in scores from pre-intervention to post-intervention.

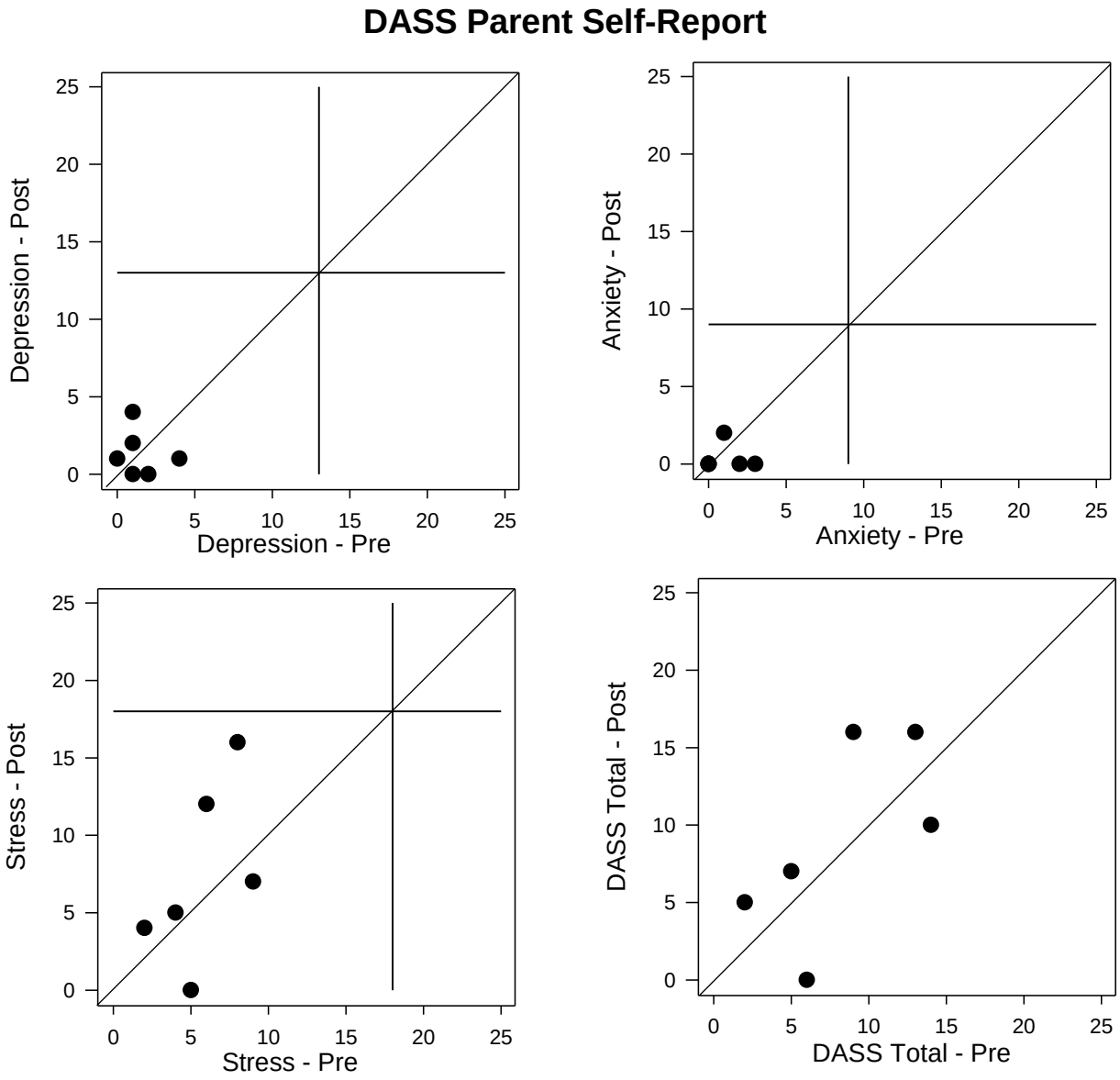

Figure 10. DASS scores for each scale from all participants.

Firstly, the subscales were analysed by examining the participant's scores as a group. The following results were found:

Depression: all scores were very low, within the non-clinical range, and showed no reliable change over time.

Anxiety: all scores were also very low, within the non-clinical range, and showed no reliable change over time.

Stress: the scores showed variability in level within the non-clinical range over time; one score showed a reduction in stress from Time 1 to Time 2; three scores showed no change; and two scores showed a worsening of stress over time.

Total scores: one score showed an improvement over time; three scores showed no change; and two scores showed some worsening of overall symptoms.

Secondly, the scores were analysed by examining the changes for each participant. The results are as follows:

Participant A: the depression and anxiety scores were very low within the non-clinical range and showed no reliable change. The stress score showed worsening of symptoms over time (6-12) but still remained within the non-clinical range. The total score also worsened in line with the stress score.

Participant B: the depression and anxiety scores were very low within the non-clinical range and showed no reliable change. The stress score worsened over time (8-16) and moved from the non-clinical range to the mild range. The total score showed some worsening, however it was not considered reliable.

Participant C: The depression and anxiety scores were very low within the non-clinical range and showed no reliable change. The stress score and the total score showed a reduction over time within the non-clinical range (5-0 and 6-0 respectively).

Participants D, E and F: all scores were very low, within the non-clinical range, and showed no reliable change.

The Conflict Behaviour Questionnaire (CBQ) (Robin and Foster, 1989) data was examined for changes in the parent's and adolescent's perceptions of parent-adolescent conflict. Table 3 presents the CBQ data showing pre-intervention and post-intervention scores.

Table 12.

CBQ data showing pre-intervention and post-intervention scores for parent-adolescent conflict.

Participant	Pre-intervention	Post-intervention
Parent A - Adolescent	2	2
Adolescent A – Mother	8	2
Adolescent A – Father	2	3
Parent B – Adolescent	3	0
Adolescent B – Mother	1	0
Adolescent B – Father	8*	5
Parent C - Adolescent	4	7
Adolescent C – Mother	5	5
Adolescent C – Father	0	1
Parent D – Adolescent	5	2
Adolescent D – Mother	1	10*
Adolescent D – Father	0	10*
Parent E – Adolescent	12	2
Adolescent E/F – Mother	2	5.5
Parent F – Adolescent	12*	5
Adolescent E/F – Father	2	3
Parent mean	6.33	3
Adolescent mean	2.9	4.45

*Distressed status (CBQ-20 normative data)

The subscales were analysed by examining the participant's scores as a group. The following results were found:

Parents: Four participating parents showed improvements in parent-adolescent conflict between pre-intervention and post intervention, one parent showed no change in scores over time, and one parent showed a worsening in scores. Five parents scored conflict within the non-distressed range and one parent's score moved from distressed to non-distressed.

Adolescents: Six of the 10 scores showed a worsening in adolescent-parent conflict over time with two of those scores moving from the non-distressed range to the distressed range. Three scores showed an improvement in adolescent-parent conflict over time with one of those scores moving from distressed to non-distressed, and one score showed no change (within the non-distressed range).

The Client Satisfaction Questionnaire (CSQ) data and was examined to assess the participants satisfaction with the GTPPP parenting intervention. The group average was 95% and suggests a high level of satisfaction.

5.7 Family Feedback

At the end of the final family discussion (post-intervention), each family was given the opportunity to describe their experiences with the programme, what strategies they found most effective and their perceptions of changes in the family after the intervention. All families indicated specific parenting strategies which were helpful. These included: family meetings/discussions (four families); family rules (two families); behaviour contracts (four families); risk-management plan (one family); and calm prompting (one family). There was improvement in parenting confidence and positive changes in parent and adolescent

behaviour for four families. Four adolescents thought the changes in the way their family functioned were “good” and “fair”. However, one adolescent felt stressed at the changes. Three families mentioned that they were happier and that the parent/adolescent relationship had improved. All parents enjoyed the course, enjoyed meeting other parents and found the facilitator friendly and informative.

5.8 Summary of results

In summary, positive changes in adolescent behaviour were found in four families, with stronger results achieved in the three families who implemented the behaviour contract. The acquisition of self-management skills increased over time. During the family discussions, three self-management skills were demonstrated at baseline, an average of four skills were used at mid-intervention and six skills were demonstrated at post-intervention. During the three telephone consultations, seven self-management skills were consistently demonstrated, and the total number of skills used in each session increased over time. Positive changes were found in parental perceptions of dysfunctional parenting (laxness and over-reactivity), adolescent emotional symptoms, adolescent prosocial behaviours and parent-reported parent-adolescent conflict. The family feedback showed that family meetings/discussions and the behaviour contract were the most popular strategies used to bring about behaviour change in adolescents. Additionally, there were improvements in parenting confidence and parent and adolescent behaviour.

The following chapter presents a discussion of the results in relation to Sanders and colleagues’ self-regulation theory.

CHAPTER SIX

DISCUSSION

6.1 Overview of results

The results of this study provide support for the efficacy of the Group Teen Triple P - positive parenting programme for promoting parental self-management competencies and adolescent behaviour change in a New Zealand sample. The main findings showed that parental self-management skill acquisition increased over-time in response to the Group Teen Triple P programme. The greatest increase of skill demonstration occurred during the final telephone consultation (session 7) and the final family discussion (post-intervention). Of the eight self-management skills tracked, three skills were demonstrated before the intervention, four skills were acquired during the intervention, and one skill was rarely demonstrated. The results also showed positive changes in adolescent behaviour in response to the implementation of the behaviour contract. The findings also suggested that a faster rate of self-management skill acquisition in the parents was associated with greater improvements in adolescent behaviour.

The secondary outcome measures showed clinically significant short-term effects of the GTPPP intervention in terms of parental perceptions of dysfunctional parenting (laxness and over-reactivity); adolescent emotional symptoms; adolescent prosocial behaviours; and parent-reported parent-adolescent conflict. However, there was no effect on parent perceptions of adolescent peer problems, conduct, hyperactivity, and total difficulties; and self-reported parental depression, anxiety and stress (although floor effects were very evident for some measures). Additionally, there was no effect on adolescent perceptions of

parent-adolescent conflict except for one adolescent who reported an increase in conflict for both parents (moving from non-distressed to distressed levels). Given that at pre-intervention the parents reported low to moderate levels of dysfunctional parenting, adolescent behaviour difficulties, parent-adolescent conflict and parental symptoms of personal depression, anxiety and stress; it may have left limited room for change over time. However, the effects found in the standard GTPPP measures indicate the strength of this parenting programme in promoting parenting competencies and adolescent behaviour change.

Additionally, improvements in parenting confidence, parenting behaviour, adolescent behaviour, and parent/adolescent relationship were evident in the family feedback.

6.2 Parental self-management skill acquisition

The first research question asked, "Do parents actually acquire self-management skills during the Group Teen Triple P programme?" The family discussion data showed that the parents transferred six self-management skills to a real-life family situation (family discussion). At baseline, most parents demonstrated three self-management skills (goal setting, monitoring behaviour, and selecting strategy). The Time 2 totals, gathered after the four group sessions and prior to the three telephone consultations, showed a small increase in skills used for the group, with the inclusion of two skills, implementing strategy and evaluation performance, for three participants. However, the greatest improvement in self-management skill demonstration was shown at Time 3 (post-intervention). The six skills demonstrated post-intervention were goal setting, monitoring of behaviour, selecting strategy, implementing strategy, monitoring implementation of strategy, and evaluation of

performance. The skill of setting future goals was rarely used and the skill of self-reward was never used. The data for the total skills used also showed that the greatest rate of increase in skill usage happened at the final family discussion, after the telephone consultations.

The findings also showed that the three telephone consultations (sessions 5-7,) delivered by the GTPPP practitioner, were effective in promoting the development of seven of the eight self-management skills in the parents. The seven skills promoted were goal setting; monitoring of behaviour; selecting strategy; implementing strategy; monitoring implementation of strategy; evaluating performance; and setting future goals. The skill of self-reward was not promoted. Additionally, as a group, the data showed that the level and rate of self-management skill acquisition for the participants increased over time.

These results may suggest that the three telephone consultations, designed to help the parents put into practice the behaviour change strategies they had learned, were the most effective part of the intervention for promoting self-management skills in the parents. Contrary to the idea that there are eight self-management skills, as identified by Sanders and colleagues (Sanders & Ralph, 2002; and Sanders and Mazzucchelli, 2013), that are essential tools for a parent to use to become a more self-sufficient problem solver, the GTPPP intervention promoted only seven skills and the parents demonstrated only six during the family discussions.

There are a number of reasons which may account for these findings. Firstly, the telephone consultation practitioner guidelines did not prompt the use of the self-reward skill. Secondly, New Zealand parents may feel uncomfortable with validating themselves. Thirdly, the parents may have wanted to focus on just the current goal for behaviour change

in each family discussion and therefore didn't need to use the skill of setting future goals to be included.

Consistent with Sanders and Mazzucchille's (2013) unifying self-regulatory framework, this study has supported the theory that parental self-management skills can be acquired in response to a parenting intervention. Additionally, this study also supported Sanders' and Mazzucchille's (2013) idea that the self-regulation approach to parenting interventions enhanced the parents' ability to solve future problems by showing that the parents could transfer the self-management skills to a real-life family context. This supported Sanders (2008) theory that, "self-regulation was a process whereby individuals acquired the skills they needed to change their own behaviour and become independent problem-solvers and controllers of their own destiny". Importantly, this research also strengthened the evidence that parental self-management skills are an essential element in the parental self-regulatory framework.

6.3 Changes in adolescent behaviour

The second research question asked, *"Does the adolescent's target behaviour, chosen by the parents, change during the Group Teen Triple P programme? "* The results showed positive changes in behaviour for all four adolescents (one family provided no data). Two adolescents' decreased undesirable behaviours (hitting sister and speaking negatively) and two adolescents increased desirable behaviours (chore completion and hanging up wet towels). The preferred strategy by three of the participants for achieving changes in behaviour was the behaviour contract. This involved a family discussion, a written agreement, tracking of behaviours, and reward or consequence. Adolescent behaviour change for these three families was apparent in trend, level and consistency. On the other

hand, the fourth participant chose to just have a discussion with her daughter and get an agreement to complete a chore however, no behaviour contract was established (i.e., no reward and no consequence). The results showed an increase in desired behaviour, however, there was inconsistency in whether she completed her task or not during the two weeks of the intervention phase.

The monitoring of adolescent behaviour results supported Sanders and associates (Sanders & Mazzucchilli, 2013; Sanders & Ralph, 2002; Sanders, Markie-Dadds, & Turner, 2001) theory that the main outcome of strengthening parental self-regulation is that the parents develop the capacity to foster self-regulation in their children and adolescents. Also, consistent with the self-regulation approach to parent training, the parents in this study demonstrated that they could take responsibility for deciding on what behaviours needed to change in themselves and their adolescents and what strategies, from the range offered in the intervention, they wished to implement to bring about that change.

6.4 Comparison of data

When the changes in parental self-management skill demonstration were compared with changes in adolescent behaviour, it was noted that the parents who acquired the skills early in the programme achieved the greatest change in adolescent behaviour. Conversely, the parent who demonstrated the fewest self-management skills and a lower skill acquisition rate over time achieved the least consistent change in their adolescent's target behaviour. One of the differences found between those who achieved successful behaviour change and the family who showed inconsistent change was the management skill of *monitoring the implementation of strategy,* specifically the use of rewards and

consequences. This may suggest that a change in parental self-regulation capacity mediates changes in adolescent behaviour.

What is more, the evidence from the family discussion data, the telephone consultation data, and the behavioural monitoring data may provide an answer to Sanders and Mazzucchelli's (2013, p. 15) question, "Do practitioner strategies that theoretically should promote parental self-regulation actually do so, and does change in self-regulatory capacity mediate changes in desired parenting and/or child outcomes."

6.5 Implications

This study demonstrated that the self-regulatory approach to parenting interventions can provide benefits for families in terms of strengthening parental skills and improving adolescent behaviour. The study also strengthened Sanders and Mazzucchelli's (2013) theory that the self-management tools provided the steps required to implement the strategies chosen by the parents, and thereby increased the likelihood of achieving the desired change in parent and child/adolescent behaviour. Furthermore, the findings also suggest that the most effective part of the parenting intervention for promoting self-management skills was the three telephone consultations. The five families, who participated in this study, showed that what they learned in the first four sessions and put into practice during the telephone consultations was transferred to a real life family context. The practical implications of these research findings may be helpful to Triple P and parenting researchers, the New Zealand Ministry of Education, and interventionists by providing information on effective strategies for measuring and promoting self-regulation and for improving outcomes for New Zealand children and adolescents.

6.6 Strengths

The strengths of this study included the high retention rate of all five families. The sample of families included diversity in terms of the parents (four mothers and two fathers, including one couple) and adolescent gender and age (two boys and three girls aged 12-16 years).

The multiple-baseline across participants Single Case Research Design (SCRD) used in this study provided a way to measure the occurrence of a set of self-regulation competencies (self-management skills) that had previously not been investigated. By tracking the occurrences of competencies over time it was possible to identify what skills the parents had prior to the intervention, what ones they acquired during the intervention and what ones they transferred to a real life family situation. This method of research also allowed an in-depth study of the rate of competency acquisition which was beneficial for comparing to the different stages of the intervention. SCRD also allowed the study of parent/adolescent interactions.

An additional strength was the large amount of data gathered using four different methods (self-report measures; parent tallies of adolescent behaviour; coded observations; and family feedback). This was helpful for comparing the results and showed that there was coherence between the different data sets.

Furthermore, the GTPPP intervention was relatively brief, consisting of five group sessions and three telephone consultations.

6.7 Limitations

Although this study may help to shed some light on the effectiveness of the self-regulatory approach of the GTPPP programme at promoting self-management skills in New Zealand parents and behaviour changes their adolescents, there are some methodological limitations that need to be considered. Firstly, there was a lack of repeated baseline measures to establish stability of self-management skills. Secondly, it lacked follow-up measures to assess maintenance of gains. Thirdly, Participant A did not attend two intervention sessions (four and eight), which may have affected her skill acquisition and data. Also, Participants E and F did not attend the third telephone consultation (session seven) and an imputed score (the average of the two previous scores) was used to estimate the group mean for Time three. Fourthly, as the participants were in the first group of parents to respond to the invitation to take part in a Group Triple P programme, they may be highly motivated to improve their parenting skills and there may not be significant change due to fairly high baseline measures. Fifthly, this study was using a small number of families and results would need to be replicated to strengthen findings. Lastly, the participants may not represent the general population of New Zealand, especially in respect to ethnic diversity.

6.8 Further Research

To substantiate the findings, future research could replicate this study and also assess whether these findings extend to parents of younger children, clinical populations, lower SES populations, and different ethnic groups. Because of time restraints, this study did not conduct any follow-up data collection and perhaps further research could investigate the maintenance of gains (e.g., three month follow-up or six month follow-up).

Group Teen Triple P may look at ways to promote the use of the self-management skill, self-reward (one that was not acquired by any of the participants) in the delivery of their programmes. It would be worthwhile to investigate if there is a smooth progress of skill development or a jump, and if so, where does the change occur. Furthermore, future research could examine the acquisition of the parental self-management skills in studies with a larger sample size, potentially in randomised controlled designs comparing GTPPP with another intervention.

6.9 Conclusion

In conclusion, this is the first study to investigate the effectiveness of Group Teen Triple P for promoting parental self-regulation by measuring the acquisition of the self-management skills. The benefits of using a single case research design has allowed an in-depth study of parent/adolescent interactions and has helped examine intervention effects on a small group of individuals, case-by-case. Using observation measures, behavioural measures, self-report measures and family feedback has led to greater accuracy, a clearer picture, and coherence in the reported data. The method of data collection used in this study has found evidence of the efficacy of GTPPP in fostering self-management skills and promoting positive changes in adolescent behaviour in all five families who participated. The results demonstrated that the GTPPP parenting programmes achieved it's goal to strengthen the parents' self-regulation to up hold the positive and caring parenting practices that promote good outcomes for children, (Sanders and Mazzucchilli, 2013).

The findings of this study are promising and may be useful to the New Zealand Ministry of Education as they look for ways to respond to the needs of adolescents and families living in post natural disaster context by equipping parents in their role of fostering self-regulation in their children. Additionally, the results may be a useful contribution to the research base of the effectiveness of Group Teen Triple P for improving outcomes for adolescents. Future research could strengthen these findings through replication and by including participants from different population groups.

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Appendix A

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE
Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: 2014/14/ERHEC

11 April 2014

Frances Sutherland
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Frances

Thank you for providing the revised documents in support of your application to the Educational Research Human Ethics Committee. I am very pleased to inform you that your research proposal "An evaluation of Group Teen Triple P in Christchurch families: a within-participant design" has been granted ethical approval.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 10 April 2014.

Should circumstances relevant to this current application change you are required to reapply for ethical approval.

If you have any questions regarding this approval, please let me know.

We wish you well for your research.

Yours sincerely

Nicola Surtees
Chair
Educational Research Human Ethics Committee

"Please note that Ethical Approval and/or Clearance relates only to the ethical elements of the relationship between the researcher, research participants and other stakeholders. The granting of approval or clearance by the Ethical Clearance Committee should not be interpreted as comment on the methodology, legality, value or any other matters relating to this research."

F E S

Appendix B

Email to Principals of Selected Schools

Hello, my name is Frances Sutherland and I am writing on behalf of Suzie Hall, a registered psychologist and Director of the Pukemanu/Dovedale, Child and Family Psychology Centre at the University of Canterbury.

This is to let you know that a free course on parenting adolescents is being run starting Wednesday, 20 August, 7-9pm. We would like to offer your parents the opportunity to participate in the course. In addition, there is an evaluation of the parents' experience of the course and its benefits running alongside the groups. Parents will be asked if they would like to participate in this evaluation, however it is entirely voluntary and they do not need to participate in the evaluation to go on the course. I have a flyer attached explaining the details.

In the next day or two, you will be contacted by phone and asked if you would be happy to inform your parents about this opportunity and to answer any questions you may have.

Regards,

Frances Sutherland

Child and Family Psychology Master's Thesis student

Appendix C

GROUP for PARENTS of TEENS

(Triple P) Positive Parenting Programme Group

It's true ..... our kids/children/TEENS didn't come with an instruction manual!

We have courses to become qualified in areas we are interested in.
We have instructions or manuals for pretty much everything we purchase ..... BUT we didn't have to pass anything to become a parent and we have no instructions for growing our children. We are doing our best to raise our TEENS, often with what we have experienced or learnt not to do.

And our TEENS are going through all kinds of changes and facing pressures and circumstances that can be very confusing and distressing and as parents we want to give them the love and support they need BUT .....

- **Do you get stuck with your TEEN in endless debates?**
- **Do you feel lost at times when trying to connect with and understand your TEEN?**
- **Do you find yourself shouting at or avoiding your TEEN in exasperation and frustration?**
- **Do you end up "nagging" your TEEN?**
- **Are you tired of picking up after them?**
- **Do you feel guilty for putting in consequences or or using threats to get your TEEN to listen?**

Come and participate in a safe learning environment where the Triple P Parenting Group will provide you with:

- **Skills to strengthen a positive parent-teen relationship**
- **Skills to encourage desirable behaviour**
- **Skills for teaching your TEEN new behaviours and skills**
- **Skills to manage problem behaviours including emotional behaviour**
- **Skills for teaching TEENS to avoid or to responsibly manage high-risk situations**

We all need a little help to develop skills to feel more self-confident and give our kids the love and guidance they require because we know that it gets really tricky and challenging at various stages in parenting.

With a focus on positive engagement and a solution focus, this course aims to equip parents with strategies they can implement straight away.

- 5 sessions and 3 "phone coaching appointments" over 8 weeks.
- To be held on Wednesday night starting 20th August; 7.00- 9.00pm, Pukemanu-Dovedale Centre, Dovedale Ave.
- The course is free
- Please contact Suzi Hall for queries or registration; suzanne.hall@canterbury.ac.nz or ph 3667001 ex 8136.
- **LIMITED to 20 Parents**

For further Information Visit: http://en.wikipedia.org/wiki/Triple_P_%28parenting_program%29
http://www.triplep-parenting.net/alb-en/positive-parenting/five-steps-to-positive-parenting-teenagers

Appendix D

Telephone: 3667001 ex 8136

Email: suzanne.hall@canterbury.ac.nz

22/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Group Teen Triple P (Positive Parenting Programme)

Dear

This letter is to acknowledge your interest in attending the Group Teen Triple P training offered by the Pukemanu/Dovedale Centre. Group Teen Triple P has strong evidence of its effectiveness in Australia and internationally. While the groups are going on, three Child and Family Psychology Masters students are interested to work with staff and research the effectiveness of the programme specifically in the New Zealand context and also in the context of parenting in the time post-earthquakes.

Involvement in the research is completely voluntary. You can take part in Group Teen Triple P regardless of whether you with to be involved in the research. You can also decide how much of the research you wish to be involved with.

We would therefore like to invite you to participate in the research so we can further help families in New Zealand. If you are interested in finding out more, Frances Sutherland, one of the research students, will call you and let you know what would be involved should you agree to taking part.

I will call you shortly after you receive this to find out if you are willing for Frances to call.

Kind regards,

Suzie Hall

Registered Psychologist

Group Teen Triple P Facilitator

Appendix E

Telephone: 027 6889503
Email: frances.sutherland@pg.canterbury.ac.nz
08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families

Information Sheet for Parents

Dear Teen Triple P Participant,

My name is Frances Sutherland and I am a Master's student at the School of Health Sciences, University of Canterbury, doing research for my thesis. I am currently interested in measuring the effects of the Group Teen Triple P programme you are doing.

My thesis will focus on the usefulness of the Triple P Program for helping parents acquire the skills necessary to foster self-regulation in their adolescents. The results may be used to revise and improve family programmes designed to improve outcomes for New Zealand adolescents. The anonymous results will be reported to in a thesis publication and may also be reported in other community and academic settings.

I would like to invite you to participate in my study. Your involvement will be greatly appreciated as it will help me build evidence for the usefulness of programmes such as these for New Zealand families.

My research will involve the following:

1) As part of the Group Teen Triple P Programme you will be doing, you/your partner and your adolescent will be asked to complete short questionnaires about your family background, functioning and wellbeing. I am requesting access to these results for my research.

2) As part of the programme you will also be filling out a ten minute daily behaviour diary to track changes in your adolescent's behaviour and I am requesting access to these results for my research.

3) During sessions five, six and seven, your facilitator will be conducting 15 minute phone calls with you to help you apply what you are learning and to apply the parenting strategies you choose to use. I am asking you and your facilitator's permission to record these calls. I will code them to find out how manageable you are finding the strategies and the usefulness of the programme to you.

4) Lastly, I will do three home visits of approximately one hour, before the programme, about halfway through the programme, and after the completion of the Group Teen Triple P programme. During these visits we will discuss the behaviour diaries and I will observe you and your adolescent having a discussion about an issue chosen by you. These three discussions will be voice recorded and will help me follow the usefulness of the programme to you over time.

Please note that your participation in this study is completely voluntary and in no way affects your eligibility to complete the Triple P Program. If you choose to participate you have the right to withdraw from the study at any time without penalty. If you withdraw, I will do my best to remove any information relating to you, provided this is practically achievable.

Please know that I will take particular care to ensure the confidentiality of all data gathered for this study. I will also take care to ensure your anonymity in any publication of the findings. Once I gather the data, your name will be substituted with an alias so that you cannot be identified. All the data will be securely stored in password protected facilities and locked storage at the University of Canterbury for five years following the study, and the raw data will then be destroyed. If you would like to receive a copy of the summary of results and final report please fill in your address on the attached consent form.

Lastly, I declare that neither I nor my supervisors have any known conflicts of interest in regard to this research project.

Thank you for taking the time to read about my study and I would like to thank you for considering participating in this research. If you have any questions about the study please contact your Group Triple P facilitator, Suzi Hall at 03 3667001 ex 8136 (direct) or suzanne.hall@canterbury.ac.nz; myself (details above); or my supervisor, Associate Professor Karyn France at 03 3642610 (direct) or karyn.france@canterbury.ac.nz. Also, if you have a complaint about the study, please contact the Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in this study, please complete the attached consent form and return it to the Group Teen Triple P facilitator in the envelope provided on your first session. I am looking forward to working with you.

Frances Sutherland

Appendix F

Telephone: 027 6889503
Email: frances.sutherland@pg.canterbury.ac.nz
08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families
Consent Form for Parents

I have been given an information sheet with a full explanation of this project and have been given an opportunity to ask questions.

I understand what will be required of me if I agree to take part in this project.

I understand that my participation is voluntary and that I may withdraw at any stage without penalty.

I understand an anonymous report of the data and the results will be presented in a thesis and may be reported in other community and academic settings.

I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify me.

I understand that I will receive a report on the findings of this study. I have provided my email details below for this.

I understand that if I require further information I can contact the researcher, Frances Sutherland or my supervisor, Assoc Prof Karyn France. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee.

By signing below, I agree to participate in this research project.

Name: _____
Date: _____
Signature: _____
Email address: _____

Please return this completed consent form to the Group Teen Tripe P facilitator in the envelope provided on your first session

Appendix G

Telephone: 027 6889503
Email: frances.sutherland@pg.canterbury.ac.nz
08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families

Information Sheet for Adolescents

Hi,

My name is Frances Sutherland and I am a Masters student at the School of Health Sciences, University of Canterbury. I am currently interested in evaluating the Group Teen Triple P program which is being offered to your parents/caregivers.

My study will focus on the usefulness of the Triple P Program for helping parents to help their adolescent's development. Any results that get published will be anonymous and they will be used to improve family programmes in New Zealand.

I would be really grateful if you would take part in my study as it will help me to find out how useful these programmes are. My study will involve the following:

1) Your parent/caregiver(s) will be completing the Group Teen Triple P Program.

2) As part of the program you and your parents will be asked to complete short questionnaires about how your family works together. There will be four questionnaires for you to complete and I am asking your permission for me to be given the results of these questionnaires.

3) Lastly, I will be doing three home visits, of approximately one hour, in order to observe you and your parent/s having a discussion about an issue chosen by you both. These visits will occur before the programme, about halfway through the programme, and again after the programme is completed. These three discussions will be voice recorded and will help me see how the programme has helped your family.

Taking part in my study is completely voluntary and does not affect your parent/caregiver/s ability to complete the Triple P Program. If you choose to be part of my study, you have the right to withdraw from it at any time. If you withdraw, I will do my best to remove any information relating to you, provided this is practically achievable.

Please know that I will make sure your name and information will kept confidential. When I write up the results, I will change your name so you cannot be identified. All the information will be securely stored in password protected and locked storage at the University of Canterbury for five years following the study. It will then be destroyed. If you would like to receive a copy of the summary of the results please fill in your address on the attached consent form.

Thank you for taking the time to read more about my study and I would like to thank you for considering participating in this research. If you have any questions about the study please contact either myself (details above); the Group Triple P facilitator, Suzi Hall at 03 3667001 ex 8136 (direct) or suzanne.hall@canterbury.ac.nz; or my supervisor Associate Professor Karyn France at 03 3642610 (direct) or karyn.france@canterbury.ac.nz. Also, if you have a complaint about the study, please contact the Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in this study, please complete the attached consent form and return it to the Group Teen Triple P facilitator in the envelope provided. I am looking forward to working with you.

Frances Sutherland

Appendix H

Telephone: 027 6889503
Email: frances.sutherland@pg.canterbury.ac.nz
08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families

Consent Form for Adolescents

I have read the information sheet and understand what will be required of me if I participate in this project.

I understand that my participation is voluntary and I may choose to withdraw at any time.

I agree to the publication of results with the understanding that my personal information will be kept private.

I understand that I can receive a report on the findings of the study if I choose to. I have written my email address below for the report to be sent to.

I understand that I can get more information about this project from the researcher, Frances Sutherland or her supervisor, Assoc. Prof. Karyn France and I can contact the University of Canterbury Educational Human Ethics Committee if I have any complaints about the research.

I agree to participate in this research and my parents have also given consent on their consent form.

Full name (student) _____

Date _____

Email address for report _____

Please return this consent form in the sealed envelope to the Group Teen Triple P facilitator

Appendix I

Telephone: 027 688 9503

Email: frances.sutherland@pg.canterbury.ac.nz

08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families

Information Sheet for Facilitators

Dear Group Teen Triple P facilitator,

My name is Frances Sutherland and I am a Master's student at the School of Health Sciences, University of Canterbury, doing research for my thesis. I am currently interested in measuring the effects of the Group Teen Triple P programme you are doing.

My thesis will focus on the usefulness of the Triple P Program for helping parents acquire the skills necessary to foster self-regulation in their adolescents. The results may be used to revise and develop family programmes designed to improve outcomes for New Zealand adolescents. The anonymous data and results will be reported in a thesis publication and may also be reported in other community and academic settings.

As you know, part of the Group Triple P Programme involves you interviewing parents on the phone three times (sessions 5-7). The material you cover in these calls is the same information I wish to obtain from the parents. Instead of duplicating these interviews, I would like to record them with both your and the parent/s permission. I will not be evaluating you as a programme leader. This is not part of my study and I do not have the knowledge to be able to do this.

Your assistance will be greatly appreciated as it will help me build evidence for the usefulness of programmes such as these for New Zealand families.

My research will involve the following:

1) As part of the Group Teen Triple P Programme the parents/caregivers and adolescents will be asked to complete short questionnaires about their family background, functioning and wellbeing. I have requested access to these results for my research.

2) As part of the programme the parents will also be filling out a behaviour diary to track changes in behaviour and I have requested access to these results for my research.

3) During sessions five, six and seven, would you allow me access to the telephone discussions with parents. This would involve voice recording the calls.

4) Lastly, I will ask the parents and their adolescent if they would allow me to observe and voice record three family discussions: prior to the programme starting; about halfway through the programme; and after completion of the Group Teen Triple P programme. This will help me follow the usefulness of the programme over time.

Please note that your assistance in this study is completely voluntary and in no way affects your delivery of the Group Teen Triple P Program. If you choose to assist you have the right to withdraw from the study at any time without penalty.

Please know that I will take particular care to ensure the confidentiality of all data gathered for this study. I will also take care to ensure your anonymity in any publication of the findings. All the data will be securely stored in password protected facilities and locked storage at the University of Canterbury for five years following the study, and the raw data will then be destroyed. If you would like to receive a copy of the summary of results and final report please fill in your address on the attached consent form.

Lastly, I declare that neither I nor my supervisors have any known conflicts of interest in regard to this research project.

Thank you for taking the time to read about my study and thank you for considering assisting in this research. If you have any questions about the study, please contact myself (details above); or my supervisor, Associate Professor Karyn France, at 03 3642610 (direct) or karyn.france@canterbury.ac.nz. Also, if you have a complaint about the study, please contact the Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to assist in this study, please complete the attached consent form and return it to me, the researcher, in the envelope provided. I am looking forward to working with you.

Frances Sutherland

Appendix J

Telephone: 027 6889503

Email: frances.sutherland@pg.canterbury.ac.nz

08/08/2014

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Evaluation of Group Teen Triple P for Christchurch Families
Consent Form for Facilitators

I have been given an information sheet with a full explanation of this project and have been given an opportunity to ask questions.

I understand what will be required of me if I agree to take part in this project.

I understand that my participation is voluntary and that I may withdraw at any stage without penalty.

I understand an anonymous report of the data and the results will be presented in a thesis and may be reported in other community and academic settings.

I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify me.

I understand that I will receive a report on the findings of this study. I have provided my email details below for this.

I understand that if I require further information I can contact the researcher, Frances Sutherland or my supervisor Associate Professor Karyn France. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee.

By signing below, I agree to participate in this research project.

Name: _____

Date: _____

Signature: _____

Email address: _____

Please return this completed consent form to the researcher in the envelope provided

Appendix K

Family Discussion and Telephone Consultation Coding Form

Participant/s: …….

Date: …… **Time: ……..** **Setting: ……..**

Coder: …… **Discussion…… / Consultation…**

Skill	Frequency	Examples
Goal setting		
Monitoring of behaviour		
Selecting appropriate strategy		
Implementing strategy		
Monitoring implementation of strategy		
Evaluation of performance		
Self-reward		
Setting future goals		
Total skills used		